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ISSN 1918-9613

Legislative Assembly of Ontario

First Session, 39th Parliament

Assemblée législative de l'Ontario

Première session, 39^e législature

Official Report of Debates (Hansard)

Tuesday 10 March 2009

Journal des débats (Hansard)

Mardi 10 mars 2009



Select Committee on Mental Health and Addictions

Organization

Comité spécial sur la santé mentale et les dépendances

Organisation

Chair: Keven Daniel Flynn
Clerk: Susan Sourial

Président : Keven Daniel Flynn
Greffière : Susan Sourial

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Room 500, West Wing, Legislative Building
111 Wellesley Street West, Queen's Park
Toronto ON M7A 1A2
Telephone 416-325-7400; fax 416-325-7430
Published by the Legislative Assembly of Ontario



Service du Journal des débats et d'interprétation
Salle 500, aile ouest, Édifice du Parlement
111, rue Wellesley ouest, Queen's Park
Toronto ON M7A 1A2
Téléphone, 416-325-7400; télécopieur, 416-325-7430
Publié par l'Assemblée législative de l'Ontario

LEGISLATIVE ASSEMBLY OF ONTARIO

SELECT COMMITTEE ON
MENTAL HEALTH AND ADDICTIONS

Tuesday 10 March 2009

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ SPÉCIAL SUR LA SANTÉ
MENTALE ET LES DÉPENDANCES

Mardi 10 mars 2009

The committee met at 0911 in committee room 1.

The Vice-Chair (Mrs. Christine Elliott): Good morning, everyone. Welcome to the first meeting of the mental health and addictions committee. The Chair should be with us shortly; I understand he's been stuck in a little bit of traffic. On his behalf, I'd like to welcome everyone. I think this is going to be a terrific committee. We look forward to working together on this committee and to developing a provincial mental health strategy and making recommendations to the government as we go forward.

APPOINTMENT OF SUBCOMMITTEE

The Vice-Chair (Mrs. Christine Elliott): This is really an organizational meeting, the first order of business of which is to develop the subcommittee for conducting business. For that, I would like to call on Mr. Balkissoon, please, to make a motion.

Mr. Bas Balkissoon: I move that a subcommittee on committee business be appointed to meet from time to time at the call of the Chair, or at the request of any member thereof, to consider and report to the committee on the business of the committee;

That the presence of all members of the subcommittee is necessary to constitute a meeting; and

That the subcommittee be composed of the following members: the Chair as Chair; Mrs. Elliott, Mrs. Van Bommel, M^{me} Gélinas; and that substitution be permitted on the subcommittee.

The Vice-Chair (Mrs. Christine Elliott): Is there any discussion on that motion?

M^{me} France Gélinas: I was wondering if we could put on the record, by any chance—who's Chair?

The Vice-Chair (Mrs. Christine Elliott): Mr. Flynn is the Chair.

M^{me} France Gélinas: Oh yes, thank you. Erase that; the question was never asked.

The Vice-Chair (Mrs. Christine Elliott): Is there any further discussion? If not, all in favour? Carried.

MENTAL HEALTH
AND ADDICTIONS STRATEGY

The Vice-Chair (Mrs. Christine Elliott): Next, I think what we'd like to do until Mr. Flynn gets here is just go around and have everyone just give us some idea

of what your expectations are for the committee, how you would like to see the committee formed. There are lots of issues that we need to talk about in terms of the order that we're going to proceed in, how we're going to organize our work, developing a work plan, figuring out travel, where you think that we need to be, how much travel needs to be involved. There is a whole budgeting process for that, as you know. So perhaps if we could start with Mrs. Van Bommel and we'll just go round.

Mrs. Maria Van Bommel: As the parliamentary assistant to children and youth services, children's mental health is very important from my perspective as PA, but also as a mother and a grandmother. I see the impacts of mental health on all children, especially as they mix together in a school environment. So that's very important.

I think we need to certainly discuss some of the issues around aboriginal mental health. Again, I have five First Nations bands in my riding, and there's a real impact there; you can see that.

I see this as very broad-reaching. I think we're going to have our challenges as a group: Where do we focus? Because when we talk about aboriginal and children's mental health, we can talk about fetal alcohol. There are so many different ways that this can play out. I think our challenge will be to be able to address things well, because there are so many things that we have to deal with.

The Vice-Chair (Mrs. Christine Elliott): There certainly are many facets to it.

Mrs. Maria Van Bommel: Absolutely.

Mrs. Liz Sandals: Given my background as a trustee, and now the parliamentary assistant to the Minister of Education, clearly children's mental health issues are very important. I think we often find that the first realization that a child has mental health issues is in the school. The whole issue of where the community supports are for the child: how do you get the referrals, the linkages, and building the teams in the community that can really support a child who has mental health issues, but we also see issues around drug addiction or alcohol addiction treatment for youth—how do you get that capacity, as opposed to adult? Teenagers with eating disorders: How do you get support for that as opposed to adults? Because sometimes the services are hived off based on age, and even if the service is available for adults, it may not be available for youth. So that's certainly, from a children and youth point of view, something I'm really interested in.

I also have a psychiatric hospital in Guelph. It's the only psychiatric hospital that does a dual diagnosis of schizophrenia and addiction. It's the only psychiatric hospital in the province that will take those patients, which means that we've got a lot of outpatients in our community who have been released from those programs who have either schizophrenia or addiction issues. I think we also need to think about what the outpatient supports are in the community, the community mental health supports for adults who have some very difficult issues. How do we provide the community supports? From my community point of view, that's an issue that really presents.

The Vice-Chair (Mrs. Christine Elliott): I would certainly agree, coming from an area that has a large mental health centre—

Mrs. Liz Sandals: You've got a similar thing.

The Vice-Chair (Mrs. Christine Elliott): Yes.

Mrs. Liz Sandals: You asked about travel. I'm sure that here in Toronto we can do hearings where we invite experts. When we travel, it's probably important that we speak to the people who are on the ground in communities with a variety of sizes and demographics. I think it's important that we actually both hear and, as we're travelling, go and visit some of the actual programs, so that we're not just talking to people representing a program or a point of view, but that we actually maybe do go and visit a few programs so that we can see for ourselves what's happening with programming in communities.

The Vice-Chair (Mrs. Christine Elliott): I think that's an excellent idea, because there are many really innovative programs in a number of communities that we could perhaps use as a model for service delivery in other parts of the province. I think that's a great point.

Mr. Jeff Leal: As parliamentary assistant to the Minister for Aboriginal Affairs, looking at mental health for First Nations communities is certainly a priority of mine and, I think, a priority, certainly, of this committee. There's such a difference in terms of access to services. I have two First Nations in my riding of Peterborough in southern Ontario, and their access to services is far different than our First Nations communities in the far north, where some of them are accessible by a road, but many are not accessible by road and often the only way that you can get in to provide services to those communities is by airplane.

0920

In terms of logistics, there should be an opportunity for us to visit some of those communities in the far north that are not accessible by road but, indeed, accessible by air. We may look at scoping the number of people who may be making that visit during the fact-finding part of our task. It may not be necessary to have the full committee, but certainly a representative from each party in terms of going into these communities and spending a day or two to really get a sense of some of the conditions they're faced with—a real tragedy of eight-, nine- and 10-year-olds. That's something we need to look at very seriously.

The Vice-Chair (Mrs. Christine Elliott): That's great. I certainly agree that some of the needs of the people in the north, where there are concurrent disorders, mental health and addiction issues—it will be really important for us to do that, and certainly your expertise in that area will be very valuable to the committee. So, thank you.

Ms. Helena Jaczek: I suppose for me, one of the most important things we need to do is to really identify the needs that are out there. Looking at the resolution that we passed, it is a huge task. If we look at what Senator Kirby did, it could become almost overwhelming. I need to know the size of the problem, the size of children's mental health needs, the size of the psychotic population, that kind of sense of what we're looking at. Obviously we need to know what programs are out there and do that traditional gap analysis: "These are the needs. This is what we have. What can we do?"

I like to think of myself as a very practical person. So I'd like to see perhaps a few very practical recommendations coming out of our report. I have a feeling that we won't be able to do as much as we probably all would want to do, and I suppose that's where it's going to be very critical to focus in as we go forward, where we can find those solutions. There may be areas where we have to say, "We've looked at this and this requires further study."

When you talk about one in five individuals having a mental health issue at some point in their lives, that is an overwhelming task to solve all those kinds of issues. So I hope we will be able to, as we go forward and we assess the needs, come up with a couple of areas that perhaps we do really, really well.

The Vice-Chair (Mrs. Christine Elliott): My own hope would be that we would first identify what the problems are, because you can't deal with them until you know exactly what they are, and then develop a series of priorities, I suppose, because you can't do everything all at once, but to develop perhaps a long-range plan that can be implemented over the course of however many years, recognizing that there are some things that are more urgent than others. So I agree with you.

Mr. Bas Balkissoon: I totally agree with Ms. Jaczek in terms that we've got to focus on the needs, focus on the things we do and look for those missing gaps. I guess I'm here as the parliamentary assistant to the Minister of Health, but I've had some personal experiences with friends and relatives that I just want to share with you. Today in the workplace, in the corporate world, if there's someone suffering over mental health, stress or whatever, there's a tendency in that world to push that person aside, leave them on their own and really not provide them with the professional help that they need, and all you're doing is making it worse. I've seen that happen to a close friend of mine, and eventually he did take his own life, which was unfortunate, but the system didn't respond to him. Also, at the same time, I saw this person bounced in and out of hospital, and there was no continuum of service to support him. They'd go into hospital for a week or two

and then the doctors would say, "Okay; they're back to normal. They can live alone," and they'd be discharged. They'd go back to their home, but there was really not the support for that person unless they took the initiative to get out and get help. I saw a huge gap there.

As we go through this, I totally agree with you that we have to look at priorities that we can solve, and those that we can't solve immediately, we at least have a long-range plan to deal with.

The Vice-Chair (Mrs. Christine Elliott): I agree. I think that has been part of the problem up until now with all governments: recognizing that there is a huge need out there but not really having a plan to address things in an orderly fashion. What you end up with is having piecemeal things that come up in every budget that are meant to help and do help to some extent but don't really address the overall picture. I think it is important for us to develop that plan.

Ms. Sylvia Jones: I would like to see us do a little bit of, for lack of a better word, research here first. That would give us an idea of where we need to travel, maybe to some parts of the province that are doing some unique things that we would want to focus on a little more. I think we all have experience in our own riding of what kind of gaps there are in the service. What I'd like to see is a little more time spent on, "This is what's happening in other parts of the province, and those are maybe the opportunities where we want to go and delve in a little deeper and see what opportunities there are."

The Chair (Mr. Kevin Daniel Flynn): My apologies. A good way to start the meeting—in traffic.

I'm assuming we're having a discussion, just going around. We got as far as you, Sylvia? Are you the first?

Ms. Sylvia Jones: No. France is—

M^{me} France Gélinas: Ms. Elliott is next.

Mrs. Christine Elliott: Go ahead, Ms. Gélinas. I'll go at the end. It's your turn next.

M^{me} France Gélinas: I would say that I'm in agreement with most, if not all, of the comments that have gone around. I like what Helena said: You have to identify the gaps so that you can move forward; you have to identify the population. I really like what—sorry; I'm not going to do very well with your last name. I'll just call you Bas for now. You said that treatment for mental health, even if somebody is well followed in the primary care sector and the psychiatrists are giving it their best, is not enough. They need the social support. They need housing. They need help with finding jobs.

For some people with mental illness, the health care sector has the solution. You have depression, you're being followed by a counsellor, you're getting medication, and you get better. For other people with severe mental illness, the solution is not solely within the health care system. Part of it is there, but the solution is very much outside of this.

We used to have a homeless clinic; 80% to 85% of our clients had severe mental illness. The people who are homeless in Sudbury have severe mental illness, day in and day out, winter and summer.

I would like us to make sure that we include—I don't want to call it "categories," but in the line of what we say is a well-defined population. The needs of children with mental health problems are very different from the need of a severely mentally ill 50-year-old man, to make sure that we look at: How do we prevent? How do we treat? How do we support? What kind of changes need to happen not only in the treatment option within the health care system but also within the broad determinants of health that affect the lives of those people? The main ones that come to mind right are the justice system, housing, education and jobs. I agree with everything else that was said.

The Chair (Mr. Kevin Daniel Flynn): Any further comments? Christine?

Mrs. Christine Elliott: Just to wrap up, I agree very much with what France is saying. My hope for this committee is to recognize that it's not just a mental health issue within the health ministry but it is looking at the holistic person and all of the needs that that person has to get well and to stay well. That's where the housing part is very important.

The justice part I think is also very significant. And looking at the various populations, the homelessness aspect of it, I completely agree that there's a large number of homeless people everywhere who have mental health and/or addiction problems, and in order to get them to a situation where they will want to stay in housing, stay on medication and get well, we need to look at all aspects of their life. It's not just one piece to say, "You need to have access to community mental health services." They need help with housing, vocational supports and everything else in their life.

0930

I think that's very much what the entire committee is looking at, so it does become a very big task, but I think it's one that is going to end up in a result that's going to be very meaningful for all of us and for all the people in Ontario who need our help.

The Chair (Mr. Kevin Daniel Flynn): Any further comments this morning? Did we establish a date for the first meeting of the subcommittee? That's something we can do after the meeting. Are there any further comments? Any other business?

Mrs. Liz Sandals: We've sort of gone around and talked generally about what it is we bring to the committee and what it is we want to see the committee discover. We haven't really had any discussion about, "Okay, that's what we want to do now. How do we want to do it?" I understand you're going to have to sort out the details at subcommittee, but I wonder if we should have any sort of general discussion about how we see us doing the work.

The Chair (Mr. Kevin Daniel Flynn): Well, let's do the same thing again, starting with Ms. Van Bommel.

Mrs. Maria Van Bommel: Actually, as a member of the subcommittee I would really like to hear from everyone else. When we get to the point of deciding on dates and that sort of thing, I'll certainly make my own needs

heard, but I would like to hear from my colleagues as to what they need to have happen in order to, as Liz said, make sure that we have our meetings in a way that we can all attend, and what we will do around the issues of travel—when it is best for us to travel and that sort of thing.

The Chair (Mr. Kevin Daniel Flynn): So we need a regular meeting time that suits all our schedules. I think we were looking at Wednesday in the late afternoon, something that we realized may be open for a number of us. That was somewhere around 4 o'clock, I think.

Interjection.

The Chair (Mr. Kevin Daniel Flynn): Yeah. We were looking around the noon hour, but apparently that didn't work for a number of members. Towards the end of the afternoon there are rooms open, and apparently people's schedules were—

Ms. Sylvia Jones: So we're talking 3 o'clock?

The Chair (Mr. Kevin Daniel Flynn): I think we were talking 4, but there's no reason it couldn't be 3, if that suited people's schedules better.

Mrs. Liz Sandals: It may be that it has to be following routine proceedings.

Interjection.

The Chair (Mr. Kevin Daniel Flynn): The clerk's just reminding me that with our new schedule, the House would be doing its routine proceedings at 3. So if any members had any statements, petitions, that type of thing, it would conflict—

Mrs. Maria Van Bommel: Could we start at 3:30? That would make sure everyone at least was able to attend routine—

Mr. Bas Balkissoon: Or right after routine—

The Chair (Mr. Kevin Daniel Flynn): Or right after routine proceedings.

Mrs. Maria Van Bommel: Right after routine proceedings.

Mrs. Liz Sandals: Yes, 3:30 gets you through statements and ministerial statements. All you'd be missing at 3:30 would be petitions. You could get your petition on a different day.

The Chair (Mr. Kevin Daniel Flynn): Okay.

Mrs. Liz Sandals: We've talked a little bit about where we need to travel to, but it seems to me that this spring it would be useful to do the sort of fact-finding, expert testimony part, because that's the work that we can be doing on the Wednesday afternoons here in Toronto. I don't think the fact-finding on this is easy. For example, in the education system we don't really count the kids with mental health issues; we have special education categories. So there may well be kids who are identified as behavioural, or some other special education category, who also have mental health issues. But there may also be kids who aren't identified for special education reasons because they don't need special education assistance, but who may well have mental health issues. So I know from my sector that while we may, as I said earlier, be the discoverer of the problem, we don't, for education purposes, have a mental health category. We

can tell you how many kids there are with special ed. needs that might overlap, but we really don't have any count. Then it's over to children and youth services, and I'm not sure how complete their data is either.

The data collection piece is non-trivial, certainly on the children's side; I'll let other people speak for the adult side. I think we need to have a discussion about how we want to collect data, what data we need and who we ask it for. We may need to speak to the different ministries about what they have and then go from there, even with some preliminary recommendations about what needs to be developed, because the first gap that we identify may be simply that we have no way of finding out what it is we would like to have as the starting point.

Then I think it would also be helpful if we identified some of the experts that we would like to talk, and then try to focus travel more on what's going on in communities.

Mr. Jeff Leal: In terms of visits and in terms of the logistics, if we think about going into Attawapiskat or Kashechewan, then perhaps June or July, August, September, in terms of having relatively good weather to get in. I think it's absolutely essential to do some fact-finding right on the ground, particularly in those communities, to understand the depth of despair when it comes to accessibility of mental health services for many of the very isolated First Nations communities. There's also a challenge here—of course INAC, Indian and Northern Affairs Canada, plays a role—this age-old, and I think most unfortunate, issue of jurisdiction, the constant finger-pointing. I think we've got to drill down and really get to the bottom of it, particularly for this group that really lacks access to many of the necessary services for the well-being of their communities.

The Chair (Mr. Kevin Daniel Flynn): Very good. So you were talking about spring/summer?

Mr. Jeff Leal: You know, maybe June. I think tentatively the House is going to rise, according to the new calendar, on Thursday June 4. So I think there is some time, in consultation with our colleagues opposite, to look at doing some fact-finding visits, maybe within that window.

Ms. Helena Jaczek: It's my understanding that the Minister of Health and Long-Term Care has established an expert panel. I'm not sure if Bas can enlighten us, but presumably they've done a certain amount of data collection and fact-finding. I'm not sure what stage they're at, but it would seem very useful to at least have their input.

One of the things that has started to happen is that I'm being approached by people wanting to come and meet with me in relation to being on the select committee. Now, of course, if they're from my riding, people that I basically know, I'm meeting with them anyway. But at this point I've said that there will surely come a time that they can approach the committee as a whole. I presume that we will be receiving people who just simply wish to come and share their story. Am I correct in that?

The Chair (Mr. Kevin Daniel Flynn): Yes, you are.

Ms. Helena Jaczek: Because that would be also important to know, looking ahead, when we might be taking those types of deputations here, so we can give them a sense of timing as well.

0940

The Chair (Mr. Kevin Daniel Flynn): I think the intent would be that the subcommittee would take all the information that they got from the other members today to their first meeting and start to establish at least the rough outlines of a work plan for the entire term that the committee is in existence and see where various things fit into things. I think we probably won't be travelling when the House is sitting, for example. The advice from Jeff to travel in the summer probably is quite good advice. Hearing from other people, hearing from the experts and what I've heard from various members anecdotally is that they prefer to do that first; they prefer to do that early in the process. I think Liz just backed that feeling up as well. So really the schedule is open, and it's really a matter of what's the best way to get everything done that we need to get done, given the confines of the House sitting and the inability to travel then. It's really a matter of scheduling.

Mr. Bas Balkissoon: I guess the minister has an expert panel working on this, and it has been quite a few months since it has been happening. I'm not sure where they're at, but it might be a good idea for us to at least know what that panel is doing so that we don't duplicate their work. I think what we should be doing is looking at how we complement each other, because I suspect that they're mostly professionals in the medical field, whereas our work should include the community and the service providers on the ground etc.

In my mind, we have to start with some research so all of us get up to speed to understand the complexity of this particular issue. It would be nice for us to travel early, but I would rather travel after I have a good handle on what it is I'm looking for and what it is I'm dealing with. I'd put travel as an issue. If it happens in June, fine; if it happens in September, that's fine. But really, the research that I see that we need is in terms of: What is out there in terms of services? What is out there in terms of research? What is it we need to do as a committee to go forward in our work? Somehow we have to document those gaps. After we do that, we set the priorities and we look at ways of how we could take on this particular challenge. Ms. Gélinas made some good points in terms of: We have to deal with this from prevention, treatment and then the supports that are there for it. That would be my comment on how we work.

Mrs. Christine Elliott: I would certainly agree that we should do our basic research first before we undertake the travelling hearings, just so that we will have some context in which to place the comments that we will be receiving.

It might be useful to see if we could meet with Senator Kirby, because he has some experience with how to structure a committee like this, and get from him what worked best and maybe what didn't work as well, to give

us some idea of our own work plan and how we should be moving forward. Then, perhaps, we deal with the minister's committee, which already has done some work, to determine what it is that they have already, to take the benefit of their research, and then figure out what else we need before we travel.

Ms. Sylvia Jones: I couldn't agree more with what Bas—sorry; Mr. Balkissoon—said. I really want that background material and for all of us to be on the same page in terms of that material available to us. The suggestion of meeting with the expert panel on mental health that has already been struck and with Kirby: Those, to me, would be the first steps that we should be doing in the next number of months.

M^{me} France Gélinas: Here again I agree with what people have said before me. That happens when you're last.

The Chair (Mr. Kevin Daniel Flynn): We'll start with you next time.

M^{me} France Gélinas: I like the idea of complementing the work that is being done by the Ministry of Health right now so that we spend our efforts where they will bear the most fruit.

I see the research and the fact-finding at the beginning to be twofold: to look at the state of the people living with mental health issues and identify the gaps; also, identify the best practices and innovative programs out there so that, as we travel, if we have identified innovative programs, it would be a good idea to go and see them on-site as well.

My last little part is: Anyplace up north in June, the bugs will drive you insane. If we want to experience mental anguish for ourselves, it's a sure fit.

Mr. Jeff Leal: This committee is only for the brave of heart.

Mrs. Liz Sandals: So you recommend we do that in last August or September, after the black flies dry up.

M^{me} France Gélinas: Pretty much.

Ms. Sylvia Jones: Can I just add one? It's more a question than anything. We've talked about how it's important that we don't just focus on the health part of the mental health, that we get the other ministries engaged, whether that's justice or housing. I'm wondering if there is an opportunity at that first stage for us to have those appropriate ministries share with us some of the things that they are working on or even the challenges that they are experiencing because of the mental health issues within their own client base.

M^{me} France Gélinas: Just a little comment: I had the opportunity to visit the Sudbury jail in January, and I was surprised at how many of my previous clients were there. I knew a lot of people who were in jail, mainly people with severe mental illness. It was striking as to how many were there. I knew about it, but it really hit me when I visited the jail.

The Chair (Mr. Kevin Daniel Flynn): One area that I know doesn't get the attention I think it deserves because of perhaps the social stigma that's still attached to mental health is the impact it actually has on the

economy. The corporate sector, for example, deals with this on a daily basis, but they deal with it behind the scenes. Quite often it's not just the people we hear about on the shop floor; it's quite often the people climbing up the corporate ladder a few rungs too. Certainly the impact, I think, is starting to be understood, the impact on business on a daily basis of not dealing with some of these issues, and not so much mental health—obviously that's there—but the addiction issue as well is something that I think has been sort of shovelled under the rug for a fair amount of time. There are people in the corporate sector now who are beginning to speak out about the cost of addictions to our economy on a daily basis. It'd be interesting to get some of those people to testify before the committee as well.

Mr. Jeff Leal: I don't know whether he's available or not, but a person for whom I have tremendous respect, who has a lot of depth of knowledge on this issue because of his family experience, is our ambassador to the United States, Michael Wilson. I don't know his schedule. It's probably very full, but I know he's back in Toronto. As an individual who was in the corporate sector for many years, was a federal finance minister and an ambassador to the United States—a most distinguished individual—it might be worthwhile to hear from him. He has some tremendous insights into mental illness because of the suicide of his son at a very young age.

The Chair (Mr. Kevin Daniel Flynn): Any further comments on this?

Two things: Obviously this will result in a budget that will need to be approved once we get the work plan.

Ms. Elliott.

Mrs. Christine Elliott: I was just going to say that there is a group that deals specifically with the economic effects of mental illness in the workforce—Bill Wilkerson, whom Mr. Wilson also knows. So he would probably be a good person to speak to.

The Chair (Mr. Kevin Daniel Flynn): Very good. As I said, this will probably, after the subcommittee has met and is starting to get to some sort of firm schedule and a firm work plan, result in a budget.

One of the things that was being discussed was the research capabilities of the committee, whether the committee was satisfied with the research ability we have in-house and whether that research ability will be available as much as we need it, or is there a need to go to outside resources to meet the demand, not from a quality perspective but from an availability perspective? If there are any comments on that, it would be timely for the subcommittee to at least consider that. The clerk has some examples of where committees have gone outside for their research analysis on an ongoing basis.

0950

Ms. Elaine Campbell: Just to follow up on what the Chair mentioned, the memo that the clerk is handing out to you serves two purposes, the second being a response to a request that the Chair had made to the research service through the clerk about our past experience in terms of working with committees like this. We've put together

a bit of information on three select committees that have met over the last 20 years here at the Legislature. The memo that you have in hand right now gives you a bit of an overview of how each committee was established, what its mandate was, what the research service did and what we did with respect to outside consultants and research analysts. You may want to look that over.

The Chair (Mr. Kevin Daniel Flynn): I know everyone is seeing this for the first time, obviously, but if there are any feelings or if you've had any thoughts about how the research might be approached, this would be a good time to bring those forward.

Ms. Sylvia Jones: Just at immediate first blush, I think that at least for the initial stages Ms. Campbell will be able to compile and prepare for us some of the material that is already out there without the need of additional research abilities.

The Chair (Mr. Kevin Daniel Flynn): Any other feelings on that?

Mrs. Maria Van Bommel: Just looking at what Ms. Campbell has provided, I get the sense that at some point all of these committees had to go outside and hire, but it doesn't really indicate where that happened. As Ms. Jones said, maybe initially, in the early stages, we did it internally and used our internal resources, and then at some point it became evident that you needed to get in more human resources because you just don't have the capacity within the Legislature to do all of that. Maybe we need to start as Ms. Jones has suggested, but it becomes evident, as you read this research, that at some point everybody needed to go outside.

The Chair (Mr. Kevin Daniel Flynn): Yes, and if there's a sense that that may happen, it needs to be included in the budget. If it's approved and not used, that would certainly be a good thing, but if it wasn't included in the budget and we found that we needed the research, then we'd obviously have to go back.

Mr. Bas Balkissoon: I tend to agree with Ms. Jones, but you should budget for it because I think that somewhere during this process we're going to need somebody to bring all the paper together and structure the final report, and I don't see that coming out of the current research process we have as a committee. We will need somebody who is an expert in the field or has some familiarity with the field to help us with the final report somewhere down the road. I would suggest that you budget for it, and the subcommittee can make a decision as we go along.

The Chair (Mr. Kevin Daniel Flynn): Any other comments on research?

Ms. Helena Jaczek: I would tend to agree; I think we should budget for it. This is an extra, so to speak. I don't think it was anticipated within the normal business of our regular committees. It strikes me that it is a fairly onerous task, as Bas says, to pull it all together, although I think there will come a time when we can make that decision better. I think it would be wise at least to budget for that to have some financial capacity.

The Chair (Mr. Kevin Daniel Flynn): Very good. Any further comments? Any other business? Anything

members of the subcommittee think they need to hear from the whole group?

Obviously, the next order of business will be to establish a date for the subcommittee. That can be done after the meeting, but that will be the next process.

No other business this morning? Anything we haven't covered? Last chance.

Mrs. Liz Sandals: Are you anticipating we'll meet next week?

The Chair (Mr. Kevin Daniel Flynn): I think as soon as possible. I sense that the subcommittee needs to meet as soon as possible, and then, depending on—

Ms. Helena Jaczek: Next week is constituency week.

Mrs. Liz Sandals: Okay, so two weeks. I'm not suggesting that we meet next week.

The Chair (Mr. Kevin Daniel Flynn): It would be nice for the subcommittee to be able to meet this week so we can get a feeling, at its first meeting, as to how much progress the subcommittee is going to make in one

meeting. So unless there's any other business, could we adjourn this meeting, and maybe the members of the subcommittee can stay behind?

M^{me} France Gélinas: Are we to assume that this committee will meet, not next Wednesday, but the Wednesday after at 3:30, and the room number will be circulated?

The Chair (Mr. Kevin Daniel Flynn): Yes.

M^{me} France Gélinas: Clearly?

Ms. Sylvia Jones: Or signs posted on every committee room: "You're supposed to be here."

Mr. Bas Balkissoon: Unless otherwise told.

The Chair (Mr. Kevin Daniel Flynn): That's right. This will be our home room—haven't used that term in a while.

Okay; hearing nothing, we're adjourned. Thank you very much.

The meeting adjourned at 0956.

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ISSN 1918-9613

Legislative Assembly of Ontario

First Session, 39th Parliament

Assemblée législative de l'Ontario

Première session, 39^e législature



Official Report of Debates (Hansard)

Wednesday 25 March 2009

Journal des débats (Hansard)

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Select Committee on Mental Health and Addictions

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Comité spécial de la santé mentale et des dépendances

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Published by the Legislative Assembly of Ontario



Service du Journal des débats et d'interprétation
Salle 500, aile ouest, Édifice du Parlement
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Toronto ON M7A 1A2
Téléphone, 416-325-7400; télécopieur, 416-325-7430
Publié par l'Assemblée législative de l'Ontario

LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

SELECT COMMITTEE ON
MENTAL HEALTH AND ADDICTIONSCOMITÉ SPÉCIAL DE LA SANTÉ
MENTALE ET DES DÉPENDANCES

Wednesday 25 March 2009

Mercredi 25 mars 2009

The committee met at 1635 in committee room 1.

SUBCOMMITTEE REPORT

The Chair (Mr. Kevin Daniel Flynn): Does everybody have a copy of the subcommittee report before them? Why don't we get somebody to read it into the record first and then, if there are any changes, any clarifications, perhaps we can deal with them on a point basis, just go through it with the intent of trying to get out of here by 5:30. Sound good? So would somebody like to read the—

Mrs. Liz Sandals: Do you want me to read it?

The Chair (Mr. Kevin Daniel Flynn): Yes, if you would.

Mrs. Liz Sandals: Your subcommittee on committee business met on Tuesday, March 10, and Wednesday, March 11, 2009, to consider a work plan and a budget and recommends the following:

(1) That the committee clerk prepare a draft budget for presentation to the committee on Wednesday, March 25, 2009;

(2) That the committee invite representatives from the following ministries to appear before the committee: aboriginal affairs, attorney general, children and youth services, citizenship and immigration, community and social services, community safety and correctional services, education, francophone affairs, health and long-term care: Minister's Advisory Group on Mental Health and Addictions, health promotion, Ontario Seniors' Secretariat;

(3) That the committee invite the following expert witnesses to appear before the committee: Mr. Michael Wilson, Mr. Michael Kirby, Mr. Glenn Thompson, Mr. Gordon Floyd, a representative of the Gerstein Centre, a representative of Parents for Children's Mental Health, a representative from the Durham Mental Health Services;

(4) That the committee schedule the ministry representatives and expert witnesses at its meetings on Wednesday, April 1, 8, 22 and 29, May 6 and 13 and that the meetings be held from 4 p.m. to 7 p.m.;

(5) That ministry representatives and expert witnesses be given 30 minutes to make presentations (including questions from the committee);

(6) That legislative research prepare a summary of all oral submissions (ministry, expert and public);

(7) That legislative research do a literature search regarding strategies for mental health and addictions in other jurisdictions (e.g. WHO, OECD);

(8) That, after hearing from the ministries and expert witnesses, the committee determine what more the committee needs and what form those needs should take (hiring of expert research, consultants etc.);

(9) That the committee hold public hearings in Toronto, Wednesday, May 27, and Wednesday, June 3, 2009;

(10) That the committee hold public hearings the week of June 8, 2009, as follows: one day in Windsor, St. Thomas, Hamilton and Kingston;

(11) That the committee hold public hearings the week of June 15, 2009, as follows: one day in Thunder Bay, Sudbury, North Bay and Ottawa;

(12) That the committee clerk, with the authorization of the Chair, post information regarding the committee's business one day in the following area newspapers (in English and French newspapers where possible): Toronto, Windsor, St. Thomas, Hamilton, Kingston, Thunder Bay, Sudbury, North Bay and Ottawa;

(13) That the committee clerk also post information regarding the committee's business on the Ontario parliamentary channel and on the committee's website;

(14) That interested people who wish to be considered to make an oral presentation should contact the committee clerk by 12 noon on Monday, May 4, 2009;

(15) That, on Monday, May 4, 2009, the committee clerk provide the subcommittee members with an electronic list of all requests to appear;

(16) That, after the list of requests to appear has been distributed to the subcommittee, the subcommittee meet to determine certain aspects of the public hearings (presenters, times, duration of presentations etc.);

(17) That the committee visit three First Nations communities at the end of August/beginning of September;

(18) That the committee visit a treatment centre in the United States (Buffalo or Philadelphia);

(19) That the deadline for written submissions be 5 p.m., Wednesday, June 17, 2009;

(20) That the committee clerk, in consultation with the Chair, be authorized, prior to the passage of the report of the subcommittee, to commence making any preliminary arrangements necessary to facilitate the committee's proceedings.

The Chair (Mr. Kevin Daniel Flynn): Thank you. Speaking to it, let's start with France.

M^{me} France Gélinas: I think on number 17, "That the committee visit at least three First Nations communities"—

Mr. Bas Balkissoon: Should we visit one in southern Ontario?

Mrs. Liz Sandals: Maybe we should just strike the "three" and put, "That the committee visit First Nations communities in northwestern Ontario, northeastern Ontario and southern Ontario." Is that what we want?

Ms. Sylvia Jones: Recommendation 17 doesn't make reference to only northern, so if you just add "at least," I think that would be sufficient.

Mrs. Liz Sandals: Will that cover it, and we can figure out where later?

The Chair (Mr. Kevin Daniel Flynn): Yes. Okay.

Mr. Jeff Leal: Perhaps you're right. In my riding, I have two.

The Chair (Mr. Kevin Daniel Flynn): Okay. So that's the one change. France, did you have anything else?

M^{me} France Gélinas: No, I'm okay.

The Chair (Mr. Kevin Daniel Flynn): Okay. Helena?

Ms. Helena Jaczek: Recommendation 3, I guess, "the following expert witnesses." We're familiar with Michael Wilson and Michael Kirby. I'm not familiar with Glenn Thompson or Gordon Floyd, and I don't find their names in the listings that we've been provided with related to experts. I don't know what the Gerstein Centre is either, so I wonder if there could be some clarification there, or why these particular experts were chosen.

The Chair (Mr. Kevin Daniel Flynn): I think we have an explanation I can probably provide you. What the research has done is provide us with a more extensive list of expert witnesses that we can take a look at. These were the ones that were sort of made available and suggested as people who seemed to have a leadership role.

Ms. Helena Jaczek: If we're going to sort of specifically mention individuals, I would think that Dr. Paul Garfinkel from CAMH, who also has written us a letter, would be a foremost person to hear from.

The Chair (Mr. Kevin Daniel Flynn): Yes, that was the intent. I think as we start to move through this we're going to get more and more people who are going to come forward and offer their services. That is starting to happen. What we were faced with is that at the start, we were trying to put a budget framework around a process. Certainly this isn't an extensive list; it's a list that has got us going. If there are other suggestions, certainly—

Mrs. Liz Sandals: The problem I've got with this list is it implies that these are the expert witnesses, and we would only hear others if they fit on the two days of public hearings. It seems to me that if we really sat down and talked about it, there are probably a whole lot more people who we would like to invite.

One of the things that concerns me about the expert list is that in fact it looks like we're mainly picking up

sort of Toronto-Ottawa, and that bothers me because I think the picture often looks different outside Toronto and Ottawa. We're also not picking up—well, we do have parents, but we're not picking up, for example, the association of children's mental health providers; we're not picking up the association of community mental health providers. There's a whole bunch of stakeholders. If we asked the Ministry of Children and Youth, for example, "Who are your children's mental health stakeholders?" they'll tell us who they work with. If we ask the mental health branch at the Ministry of Health, "Who are your stakeholders that you work with?" and similarly with aboriginal affairs—there are a bunch of ministries. If we say, "Could you please give us your stakeholder list on this issue?" they're going to tell us who they think we need to talk to.

I don't think we should be putting ourselves in a box as to who we're going to invite until we get a more thorough list from the ministries of who it is that actually has their expertise. We really don't want to just get research expertise. I would also be interested in talking to people who do both hospital programming and community programming. I don't know whether there's an association of psychiatric hospitals or—you know, children's psychiatric hospitals, adult psychiatric hospitals. It seems to me that we're probably just touching the surface here in terms of who we should be talking to.

The Chair (Mr. Kevin Daniel Flynn): Yes, and I think that's the point. It's a Catch-22 situation. In order for us to get going, we need a budget to start doing things; in order to get a budget, we need to start to establish a framework. As we start to move through that, I'm sure there will be other people we will choose to hear from. You've brought suggestions today, and I'm sure the committee would be quite happy to talk about them.

Mrs. Liz Sandals: I don't need to know all the names today, but we need to make this so it's clear that we may still be doing hearings in the fall. I don't know how we're going to get through, in the spring, everybody that we might possibly want to be talking to. This is sort of structured like we have to talk to everybody by June, and if you don't talk to us by June and if you don't send a written submission by June, then we're done. I don't think that's what we mean. This is fine for a starting point, but it needs to be more open-ended.

The Chair (Mr. Kevin Daniel Flynn): I think that is the intent. With the budget that Susan will be showing you, if you don't have a copy in front of you yet, there will also be a suggestion to allow for some more funding for future travel in the fall. This gets us going. This gets us out the door. People thought we should hear from the ministries, or the representatives of the ministries that chose to, to give us an idea.

Now, I'm interpreting what the members of the subcommittee said. Maria's joined us now. The subcommittee members can speak for themselves.

Mrs. Maria Van Bommel: My apologies.

The Chair (Mr. Kevin Daniel Flynn): No problem.

Mrs. Maria Van Bommel: I was carrying out my other role as PA.

The Chair (Mr. Kevin Daniel Flynn): What we've done is, we didn't start until about 25 to 5. Liz has read the existing subcommittee business into the record. We were just starting to go through some of the changes that perhaps we'd like to make.

The one change that I believe there is consensus on is that the committee visit "at least three First Nations communities" instead of "three First Nations communities."

Then we were going back, and Liz had just raised the point of, how did we arrive at these expert witnesses, and is there the potential to make that list bigger? I think there's actually the expectancy that that list will grow bigger. Research has actually provided a list that you should have before you of witnesses that they—maybe you can speak to this, Carrie or Susan.

Ms. Carrie Hull: I think we were asked several weeks ago to start a list of experts in mental health and addictions in Ontario. This is actually a first attempt. Every time I make contact with someone, I am told of other people. So, as you were saying, the list could grow quite considerably.

Mrs. Liz Sandals: I wonder if we could make it clear, Kevin, if we said in number 3: "That the committee invite the following preliminary list of expert witnesses."

The Chair (Mr. Kevin Daniel Flynn): That works.

Mrs. Liz Sandals: Then it's clear that we'll be adding to the list of experts later.

Mrs. Maria Van Bommel: And then people won't be upset if they're not in it.

Mr. Bas Balkissoon: We should say, "invite as many as necessary expert witnesses, inclusive of" that.

Mrs. Liz Sandals: That's good. So combine those two thoughts.

Mr. Bas Balkissoon: That way, if we want to add to it, we can always add.

Mrs. Liz Sandals: Yes.

Mr. Bas Balkissoon: And we will decide if they're necessary.

The Clerk of the Committee (Ms. Susan Sourial): Can you repeat that?

Mr. Bas Balkissoon: I said: "The committee will invite as many expert witnesses as necessary, inclusive of" the list that you have there already.

Interjection.

Mr. Bas Balkissoon: There you go: "inclusive of and not limited to."

Mrs. Liz Sandals: This is the starter list.

The Chair (Mr. Kevin Daniel Flynn): That's right.

Just to keep you updated, on (2), the invitations have gone out to the ministries, and it was clear that representatives could send people, should they choose to appear.

Sylvia?

Ms. Sylvia Jones: On point 2, Chair, are we not missing the Ministry of Municipal Affairs and Housing, because of the housing component?

Interjections.

The Chair (Mr. Kevin Daniel Flynn): It's not on here.

1650

Ms. Sylvia Jones: So we can add that one, then?

The Chair (Mr. Kevin Daniel Flynn): Yes. Good call.

Ms. Sylvia Jones: Thank you.

Mrs. Liz Sandals: Chair, could you clarify who we're expecting to come? Because it says, "Invite representatives from the following ministries." For example, at public accounts, we explicitly invite the deputies and say, "Bring whatever other staff you need" to explain the program we're interested in.

The Chair (Mr. Kevin Daniel Flynn): I don't think we got into the actual titles, but the expectation was it would be from the bureaucratic side; it would be the ADMs.

Mrs. Liz Sandals: And have we made that clear to the ministries, that we're expecting a deputy or an ADM, plus whatever directors or managers they need to—

The Chair (Mr. Kevin Daniel Flynn): No, we haven't specified the level of the person they should send. Hopefully, it's understood that they would send the person who would best represent.

Mrs. Maria Van Bommel: We're trying to find information, so we need to have the person who is the most capable in terms of giving us the information of what each ministry is doing and what could potentially be done. There's all kinds of things we want to know from them.

Mrs. Liz Sandals: Did the letter go to the deputies, then?

The Chair (Mr. Kevin Daniel Flynn): The letter went to the ministers.

Mrs. Liz Sandals: So is it clear to the ministers that this isn't like estimates, where we want the minister, that this is like public accounts or something where we want the administrator with the expertise?

The Chair (Mr. Kevin Daniel Flynn): It's a letter to the minister asking that they send representatives of their ministry to address the committee. It's very, very clear. So we'll add municipal affairs and housing to the list. Anything else?

Mrs. Christine Elliott: A couple of things. I certainly do agree that we will probably need to expand the list from number 3 and we may want to do some site visits too. I note from the letter from CAMH that they've invited us for a site visit. We may want to go there and perhaps other places. The Gerstein Centre is a crisis centre that has been set up. It's been in operation for, I think, about 10 years, maybe a little bit longer, named after Dr. Reva Gerstein. We were thinking that that might be perhaps another place we might want to visit.

I think Gordon Floyd is the representative for Children's Mental Health Ontario. The other gentleman—

Mrs. Liz Sandals: I think you're right. I recognize the name and I can't think why.

Ms. Helena Jaczek: It's in Toronto?

Mrs. Liz Sandals: I think that's why I recognize Gordon.

Mrs. Christine Elliott: Yes, it is. So that being the case, Chair, it would seem in terms of our scheduling that we may need to push things out a little bit and that the public hearings in June, we may want to put off until August–September, because I think there are going to be a lot of people we’re going to need to hear from here and in the visitations and so on. I would think that would take us past the end of June.

Mrs. Maria Van Bommel: And I think some of them will need more time to prepare as well.

Mrs. Christine Elliott: Yes.

Mrs. Maria Van Bommel: So June might be a very compressed time period. It means for some of them they may have to take staff people out specifically to do something like this. I don’t think we want to take them away from their core business to just deal with this. So if we give them enough time, they can manage that a little better.

Mrs. Liz Sandals: I don’t disagree with you that we’re going to have to change the time schedule. I’m just trying to figure out what you were suggesting, Christine.

Mrs. Christine Elliott: We may want to change (10) and (11) and just push those into the visits that we’re doing as well with the First Nations communities, which will mean that August and September would be very busy, but I really think that to do justice to the experts upfront and to the site visits we want to do, we will need that time in June.

Mrs. Liz Sandals: Because I was just going to say that the beauty of those two weeks in June is that we’re actually free to travel. We could take the public hearings out of May 27 and June 3 and replace those with expert hearings and maybe even have some expert hearings when we come back, but should we take advantage of the ability to—I’m not hung up on 10 and 11 being this specific list. It might even be that we want to, as you said, go and visit other programs as opposed to necessarily doing hearings. But we might want to take advantage of the ability to travel at least somewhat in June, even knowing that we would need to come back in September, when the House resumes, and do more hearings.

The Chair (Mr. Kevin Daniel Flynn): Okay, when the House comes back on September 14—just returning to my original point, we’re going to have to do this almost in blocks. I don’t think we can plan out the next 18 months of our life and where exactly we’re going to go.

I think, following up on your point, Christine, you’re saying that perhaps we need to take the late spring, early summer to hear from the experts instead of hearing from the experts and the public.

Ms. Sylvia Jones: Which is my understanding of what we had discussed preliminarily. In our last meeting as a whole we raised the issue that we’re not all at the same knowledge level, so we had hoped to do the expert witness information gathering first, before we started doing the public input and the travelling. I still very much support that, and I can see now, as we start to review

some of the stuff that research has already done, that there’s a lot of information out there that I’d like to gather before I start going and doing the travelling component. I would very much support expanding that expert list at the beginning, in the spring, so to speak, and doing the travelling in the late summer/fall.

The Chair (Mr. Kevin Daniel Flynn): Okay. Well, if we’re going to make this work, the subcommittee is going to have to work well and the members are going to have to work through the subcommittee. There’s no sense in our having subcommittees and coming back and undoing everything the subcommittees have done. If we can get a position—France, you can work with yourself, right? That’s easy, and whatever the feelings are need to be channelled through Maria so that when we do have the subcommittee meetings, we can actually start to make some progress.

Mrs. Maria Van Bommel: I think the other day when we had the subcommittee meeting, we were really biting off a whole chunk of stuff, a lot of things. We tried to create lists of people to invite. Already, there have been people pointed out to us who should have been added in the first place. I think we did a lot for a subcommittee, and I actually really appreciate the fact that we’re having this discussion right now to make sure this is done properly. This is the template for what we want to do.

I know Susan was looking for ways to deal with budget, and that was another issue. If we’re going to travel, we need to get a budget together for it. So there’s a lot that went on. I’m not defending the subcommittee, but I’m really quite happy with the way this is working right now.

The Chair (Mr. Kevin Daniel Flynn): Yes. Okay, let’s go through this. I think we’re all starting to get on the same track. One of the committee clerks prepared a draft budget. We’ll be dealing with that shortly. We’ve added municipal affairs and housing—

Mrs. Liz Sandals: Just one another question on number 2, and this would be a question for the letter: I would think that from health and long-term care, at some point we would want to meet with the minister’s advisory group and know what they’re doing, but we would still want to hear from the bureaucrats at health and long-term care. That’s like a double-barrelled one. It’s not both; it’s the bureaucrats and the group.

Interjection.

The Chair (Mr. Kevin Daniel Flynn): Okay, we’ll see what sort of response we get, then, from health and long-term care and take it from there. We’ve asked each of the ministers to send who they think is the best representative of their ministry, and if there’s more we need, there’s no harm with us going back.

We’ve changed number 3 now to read your wording, Bas, right? So we’ve moved on with that.

We’ve identified who Gordon Floyd is—he’s from Children’s Mental Health Ontario—and Glenn Thompson. I can’t put the organization in Glenn Thompson’s name, but I know that he came very highly recommended.

There seems to be consensus, then, that before the summer, instead of trying to do public hearings and hearing from the expert witnesses, we use all that time to hear from the ministries and expert witnesses and organizations—perhaps CAMH, who have offered us a tour, and they've offered to come as well.

1700

So we use the time before the summer to do the preparatory work involving those three: Is that agreed? Okay.

In number 9, we'll take May 27 and June 3, and in numbers 10 and 11, June 8 and June 15, and add them to the lists in number 4.

Interjection.

The Chair (Mr. Kevin Daniel Flynn): Actually, we don't add the June ones; just the ones in number 9. May 27 and June 3 then get added to number 4.

Ms. Sylvia Jones: So two additional dates on point 4?

The Chair (Mr. Kevin Daniel Flynn): That's right. There was another issue raised at the time, I think, when we were first trying to choose a time to meet. With the schedules quite tight, it was suggested we meet from 3 to 6. Then we realized that we had routine proceedings at 3 o'clock and we couldn't meet. So then we thought we'd meet after routine proceedings, and realized that that would make the committee start at any variety of times—it could start at 3:25; it could start at 3:45—so we tried to standardize the start time. Then it was decided that we might push it out to 7 o'clock. Now some people have suggested that the rest of the House ends at 6, so why don't we end at 6? That may be a discussion the subcommittee may want to explore: if it wants to end its meeting at 6, now that it's expanded the number of meetings it would have, or if it wants to leave it at 7, as the subcommittee was recommending. Is there any—

Mrs. Liz Sandals: Do we have authority to meet past 6?

The Chair (Mr. Kevin Daniel Flynn): We have authority to meet 24 hours a day, apparently, which is—

Mrs. Liz Sandals: But not during routine proceedings.

The Chair (Mr. Kevin Daniel Flynn): Yes. We can even meet—it's at the call of the Chair, basically, but we're trying—

Mrs. Maria Van Bommel: So when we thought that we couldn't meet during routine proceedings, because this is a select committee, we can do that?

The Chair (Mr. Kevin Daniel Flynn): Yes. What I was going to suggest, from the Chair's perspective, is that perhaps we'll change that to say "from 4 to 6," with the full knowledge that we have the ability to meet longer, should we—okay?

Mrs. Maria Van Bommel: That's right, and then if we have the occasion that we want to sit longer, we can.

The Chair (Mr. Kevin Daniel Flynn): Okay.

Mr. Bas Balkissoon: Are we restricted to Mondays, Chair?

The Chair (Mr. Kevin Daniel Flynn): Wednesdays.

Mr. Bas Balkissoon: I mean Wednesdays. If we do Mondays instead, when there is a longer afternoon—

The Chair (Mr. Kevin Daniel Flynn): If we can make that work—I mean, it's at the call of the Chair, so we're not restricting ourselves.

Mr. Bas Balkissoon: See, Wednesdays, because the House schedule starts at 3, we're sort of restricted to 4 to 6.

Interjections.

Mrs. Liz Sandals: I think Wednesday was the day most people were free—Wednesday afternoon.

Mrs. Maria Van Bommel: Yes, exactly. Some of us have other commitments in standing committees. I think that was the issue.

The Chair (Mr. Kevin Daniel Flynn): Yes. If there's a need to have a special meeting, and we can free ourselves up, that's not impossible. That can happen if someone like—

Interjection.

The Chair (Mr. Kevin Daniel Flynn): Yes, or extend the hours. So if we can just change that to 6 o'clock instead, then, with the knowledge that we have the ability to change that as well.

We aren't having public hearings the week of June 8 or the week of June 15, but Susan now knows we are having public hearings and can put some money into the budget for those hearings to be held. They just won't take place the week of June 8 and June 15.

We could change that, perhaps, the committee hold public hearings in the fall or in the late summer/fall of the year, something like that, and start to schedule times over the summer that suit our schedules as well.

M^{me} France Gélinas: There is no hope that we could do half of it in June and the other half in late summer, maybe keep the week of June 15 just to do one?

Mrs. Maria Van Bommel: For public hearings?

M^{me} France Gélinas: Yes.

The Chair (Mr. Kevin Daniel Flynn): Okay, let's discuss that. If we get through the expert hearings and the organizations that we want to hear from, is the committee comfortable with going out June 15 to do public hearings?

Mr. Bas Balkissoon: Just for that one week?

The Chair (Mr. Kevin Daniel Flynn): One week of public hearings.

Mrs. Liz Sandals: It seems to me that if we're going to travel to these—we can do the public hearings in Toronto in the fall while the House is sitting.

The Chair (Mr. Kevin Daniel Flynn): Right.

Mrs. Liz Sandals: So that's not a problem. We can take the stuff that was in (9) and move that to the fall while the House is sitting. The issue is that if we're not supposed to be travelling while the House is sitting, if we're going to do public hearings in other places, I'm inclined to agree with France that we should probably choose at least one week in June to travel to other places where we might want to do public hearings.

M^{me} France Gélinas: We're going to run out of time in August. We all sit on other committees; we all have other commitments.

The Chair (Mr. Kevin Daniel Flynn): Okay. By the time June 8 rolls around, the House presumably will not be sitting, so we have the ability to go out in those two weeks. We have the ability to go out for one of those weeks, or we don't have to go out at all.

Ms. Helena Jaczek: Would it make sense, though, as an example, if we're going to be going to Thunder Bay, if it be in the fall, that we then go to northwestern aboriginal communities? There might be some logic in combining some of the travel.

Mrs. Liz Sandals: I was just actually thinking the same thing. You might do Thunder Bay, Sioux Lookout and aboriginal communities in the fall.

The Chair (Mr. Kevin Daniel Flynn): Okay. Yes, now—

Mrs. Liz Sandals: And North Bay.

M^{me} France Gélinas: Windsor, Hamilton, Kingston the week of June 15?

Mrs. Liz Sandals: Yes.

The Chair (Mr. Kevin Daniel Flynn): Okay, so we'll do southern Ontario the week of June 15.

The Clerk of the Committee (Ms. Susan Sourial): Which one is southern Ontario?

The Chair (Mr. Kevin Daniel Flynn): Southern Ontario is Windsor, St. Thomas, Hamilton and Kingston.

Mrs. Liz Sandals: That's June 15 that we're putting that?

The Chair (Mr. Kevin Daniel Flynn): That's the week of June 15, yes.

Ms. Sylvia Jones: So we're confident that we'll be through the experts by the end of June 3? Basically, we've only added two dates for expert input, which is eight people. I'm just not sure you're—

The Chair (Mr. Kevin Daniel Flynn): That would be eight meetings, 16 hours.

Ms. Sylvia Jones: Yes, but you've got 30 minutes—it's somewhere—"expert witnesses be given 30 minutes."

M^{me} France Gélinas: We're at 30 experts.

The Chair (Mr. Kevin Daniel Flynn): Thirty experts.

Ms. Sylvia Jones: Okay.

The Chair (Mr. Kevin Daniel Flynn): This is brand new ground for us all. Thirty could be nowhere near enough; it could be way too many, you know?

Ms. Sylvia Jones: If one of those days ends up being a site visit to CAMH? I'm just trying to figure the math.

Mr. Bas Balkissoon: But you know what? As we get closer to June, we can always have another subcommittee meeting.

The Chair (Mr. Kevin Daniel Flynn): That's true.

Ms. Sylvia Jones: Yes, but you don't want to be in a position, as Maria pointed out, on May 30, of saying to people—

Mr. Bas Balkissoon: We'll know that, because we have to advertise for June 15, so at least the Chair will say to us, "Should I advertise, or are we going to go with it?" This is tentative, I would say.

The Chair (Mr. Kevin Daniel Flynn): As we start to go through it, if we appear to be running into some

problem with the schedule, we'll notice it. I'll certainly keep an eye out for it. I'm sure the staff will be right on top of it.

Mr. Bas Balkissoon: Plus you've got the whole week of June 8, when the House is not sitting, to meet every day for witnesses in Toronto, if you need to.

The Chair (Mr. Kevin Daniel Flynn): Okay, so in very general terms again, just to go over this: Spring and early summer, hear from the expert witnesses and organizations; the week of June 15, do the public hearings in southern Ontario; and then late summer and early fall, do the public hearings in northern Ontario and perhaps, if possible, combine that with the travel to the First Nations.

There may not be a huge advantage to combining them. When we're travelling to do the public hearing, the whole crew comes along: Hansard and everybody else come along. When we're going to the First Nations, it will be site visits. There may be some synergies; there may not be.

1710

Mr. Bas Balkissoon: Just those folks can stay back.

The Chair (Mr. Kevin Daniel Flynn): That's right. But the idea, in very general terms so we can start to plan our own schedules, is that around the end of the summer, the beginning of the fall, we'll be doing public hearings and First Nations visits. Is that—

Mr. Bas Balkissoon: Should we pick the week before we're about to resume, so at least we know it's that week?

Ms. Sylvia Jones: That's a short week. That's a four-day week.

Mr. Bas Balkissoon: There are four cities.

Ms. Sylvia Jones: But weren't we talking about adding First Nations?

Mr. Bas Balkissoon: He was saying he may not be able to tie the two together. If you want to tie the two together, then you've got to go the week before.

Mrs. Liz Sandals: If we're going to go into northwestern and northeastern Ontario, we need to do that late August, early September, because we already had the discussion about not doing that in the spring because of blackflies, and you don't want to do it once the snow starts to fly, or we might be there longer than we'd planned. I think we pretty much, if we're going to visit northern First Nations communities, need to be doing that late August, early September. So somehow we need to schedule those visits end of August, early September.

Mr. Bas Balkissoon: So let's schedule it August 31 for the whole five days.

Mrs. Liz Sandals: And that might be two different trips if we're going both to northeast and northwest.

Interjection.

The Chair (Mr. Kevin Daniel Flynn): Now's the time to speak up. This is where we're planning our next 18 months, so if there's an issue with that, then let's hear about it.

Mrs. Liz Sandals: So you have to go to three different ones?

Mrs. Christine Elliott: Could mid-August be considered, to just move it up a little bit earlier, that travel?

The Chair (Mr. Kevin Daniel Flynn): Mid-August?

Interjection.

The Chair (Mr. Kevin Daniel Flynn): No? That would be tough? Okay. Well, we can't do mid-August; we can't do late August. So we're into—

Mrs. Christine Elliott: Early August.

The Chair (Mr. Kevin Daniel Flynn): Early August isn't out of the question for me; it's just in the middle of the summer.

Interjection.

The Chair (Mr. Kevin Daniel Flynn): That's tough for you?

Mr. Bas Balkissoon: That's tough, and you probably wouldn't get people coming.

The Chair (Mr. Kevin Daniel Flynn): So that's putting us into September now.

Mr. Bas Balkissoon: Unless you just want to do the First Nations trip and delay the other thing until January.

The Chair (Mr. Kevin Daniel Flynn): Last week of August, the kids are going back to school. Early? Late?

Interjection: That depends.

The Chair (Mr. Kevin Daniel Flynn): That depends, yes.

Jeff?

M^{me} France Gélinas: What happened to August 24? Does that not work for everybody?

The Chair (Mr. Kevin Daniel Flynn): Jeff, and then we'll come back to you, France.

Mr. Jeff Leal: Just to give a little perspective from MAA, I think what we need on the First Nations thing—we can easily set up a sub-tour, almost. We'll pick the appropriate time, whether it's late August, early September or before we come back, and visit those communities, because I don't think we need the full committee to descend on many of these communities, as long as there are representatives from each of the three parties and the appropriate staff, and we could set up that sub-tour to go into those areas. If need be, the other half of the committee could continue doing their other visits.

The Chair (Mr. Kevin Daniel Flynn): Okay. So when were you thinking of that happening? Because it sounds like August doesn't work for anybody.

Mr. Jeff Leal: Well, late August or the first part of September, bearing in mind the blackflies and everything else that may impact.

M^{me} France Gélinas: We're into horseflies by then.

The Chair (Mr. Kevin Daniel Flynn): We don't have a calendar in front of us either, unfortunately, or do we? Okay, there we go; we do.

Ms. Sylvia Jones: When's the first constit break after the House resumes?

Mr. Bas Balkissoon: The middle of September.

M^{me} France Gélinas: No, this is the week—

The Chair (Mr. Kevin Daniel Flynn): Okay. We're back on the 14th, and October would be the—

Mr. Bas Balkissoon: The middle of October.

The Chair (Mr. Kevin Daniel Flynn): The middle of October. Was that too late to go to the First Nations?

M^{me} France Gélinas: No, that's not.

The Chair (Mr. Kevin Daniel Flynn): It's not. How does that work?

Mr. Jeff Leal: You probably wouldn't want to be much later than that.

M^{me} France Gélinas: No.

Ms. Sylvia Jones: Or could that be the southwestern Ontario component? I don't know. Whatever works, but is that week an option for people?

The Chair (Mr. Kevin Daniel Flynn): What I'm thinking of is using—

M^{me} France Gélinas: August 24 is better.

The Chair (Mr. Kevin Daniel Flynn): But August 24 ties into—let me check my calendar.

I already have it in my calendar as visiting First Nations communities; I'm way ahead of you guys. Apparently, I'm going and you guys aren't.

Mrs. Liz Sandals: I'm good with that week.

The Chair (Mr. Kevin Daniel Flynn): That's August 24?

The Clerk of the Committee (Ms. Susan Sourial): That's for the First Nations.

The Chair (Mr. Kevin Daniel Flynn): That's for the First Nations visit. Jeff, France—is that good?

M^{me} France Gélinas: Can it be arranged? August 24th?

The Clerk of the Committee (Ms. Susan Sourial): Thunder Bay, Sudbury, North Bay—

The Chair (Mr. Kevin Daniel Flynn): So now we need the northern Ontario public hearings. When is a good week for everybody for that?

Mr. Bas Balkissoon: I thought you were trying to do both together to save travel costs?

The Chair (Mr. Kevin Daniel Flynn): It really doesn't—

Mr. Bas Balkissoon: It doesn't work.

The Chair (Mr. Kevin Daniel Flynn): No, it's not going to—

Mr. Bas Balkissoon: And the four days in September, a short week, is ideal for the public hearing: four cities, four days.

The Chair (Mr. Kevin Daniel Flynn): Which four days is it that you're talking about?

Mr. Bas Balkissoon: After the long weekend in September.

The Chair (Mr. Kevin Daniel Flynn): September 8 to the—whatever? You're thinking of doing Ottawa, North Bay—

Ms. Sylvia Jones: The 7th is Labour Day. The 8th to the 11th is Tuesday to Friday.

The Chair (Mr. Kevin Daniel Flynn): That would be starting in Thunder Bay and going across Sudbury, North Bay and ending up in Ottawa. Are we all on track here? Ladies, are we all agreed on that date?

Mrs. Liz Sandals: So we'll do First Nations the week of August 24 and we'll do public hearings in the north on September 8 to September 11.

The Chair (Mr. Kevin Daniel Flynn): Does that work for everybody?

Mrs. Liz Sandals: We could conceivably, that constituency week, either in October or November, use one or two days to do southern Ontario visits. We don't need the whole week then, because if they're constituency weeks, it's nice to have some of the days to have constituency week stuff, but you could take one day in October to go south to your neck of the woods, and one day to go to Maria's neck of the woods, that sort of thing.

The Chair (Mr. Kevin Daniel Flynn): Okay, but that's not something we have to decide today.

Mrs. Liz Sandals: We don't need to decide that today. We could work those ones in.

The Chair (Mr. Kevin Daniel Flynn): And then we can plan our own personal schedules out around what we have decided today for anybody planning holidays, schools and whatever.

Mrs. Liz Sandals: So we've booked the week of June 15, the week of August 24 and the week of September 8. And everybody's cool with that? Okay.

M^{me} France Gélinas: Were you there this morning when they were saying public accounts—

Mrs. Liz Sandals: No, I wasn't, but that's what Maria was just saying to me, that I can get started here because of the way everything conflicts. I think CCPAC—the Canadian Council of Public Accounts Committees—should be the same day that the House resumes, which means we can just all go to Edmonton instead of coming back when the House resumes.

The Chair (Mr. Kevin Daniel Flynn): We're going through these now. Are there any other changes that we're going to have to make? What the clerk is suggesting is that she take this back and redo it.

Mr. Bas Balkissoon: And mail it out to us.

The Chair (Mr. Kevin Daniel Flynn): Yes, rather than try to vote on it today.

Mr. Bas Balkissoon: Because we'll have to put it in our calendar.

The Chair (Mr. Kevin Daniel Flynn): Yes, I think we're all in.

Now, point 19: The deadline for written submissions.

Mr. Bas Balkissoon: Just change it to coincide with the dates we've picked. We leave that up to you, Chair.

The Chair (Mr. Kevin Daniel Flynn): Whatever makes sense.

Mrs. Maria Van Bommel: Do we want to set a deadline at this point?

Mr. Bas Balkissoon: No, let the Chair just pick it.

The Chair (Mr. Kevin Daniel Flynn): Whatever makes the meetings work, the Chair will do.

Mrs. Liz Sandals: But if we're going to still be doing expert hearings, we may even be okay with written submissions coming in the fall.

The Chair (Mr. Kevin Daniel Flynn): Yes, I think we're going to get submissions whether we ask for them or not. I think setting a deadline is just limiting ourselves. At some point, we're going to want to prepare a draft report and we're going to have to set some sort of a

deadline, so we'll just leave that out and we'll do what needs to be done.

1720

Mrs. Liz Sandals: My sense is that if we make it that early, we'll just annoy people.

Mrs. Maria Van Bommel: They'll think we're trying to cut them off from the discussion.

The Chair (Mr. Kevin Daniel Flynn): Now, I'm starting to get a fair amount of correspondence from groups like CAMH that I want to share with the committee, and I want to bring that forward to the committee. I'm assuming there's interest in doing a tour of CAMH, so we can even start to set that up. We can even start to think about that. We have an expert list now. We said we could do 32 with the time that we've set aside, 30 minutes each. That's including ministries. I'm not sure if all the ministries will come forward. Some of them will, some of them won't, I think. All we can do is get started.

Mr. Bas Balkissoon: Yes, and you can always add to it.

The Chair (Mr. Kevin Daniel Flynn): All we can do is start inviting people. We'll start with 30 minutes, we'll find out if 30 minutes is too long or too short and we'll just make changes as we go along. We're going to be spending the next 18 months together, and this is going to be a dynamic process rather than one we establish today.

How do you want to decide as we start to move forward? The ministries have been invited. What process do you want to use to decide on the experts? You can leave it to the subcommittee members to decide, to go through this list and channel your suggestions through Maria, Christine and France. Is that good?

Ms. Sylvia Jones: That's fine.

Mr. Bas Balkissoon: Yes.

The Chair (Mr. Kevin Daniel Flynn): Okay. We can use this list. If somebody else has another list going or somebody else has other suggestions, other people they know, other correspondence they're getting, then we could do that through the subcommittee. So the subcommittee needs to meet again fairly soon to develop that list, bring it back to the full committee for approval and then do the invitations.

Mrs. Liz Sandals: Could we get the PAs for MCYS and for health to check with their ministries about who those specific ministries would consider to be their mental health stakeholders? Because we don't want to insult major mental health stakeholders by not—

Ms. Helena Jaczek: For health promotion, I can tell you, it's really only CAMH. I can certainly look as well, but from my understanding, that is the only stakeholder they deal with.

COMMITTEE BUSINESS

The Chair (Mr. Kevin Daniel Flynn): Susan had drawn up a budget based on the old schedule, and my sense was that we should at least make a financial allowance for more travel or for more consultation, either in the fall or the winter of 2010, before the report is

drafted. Susan, do we have the budget now in people's hands?

I'm thinking we might want to do the budget today if we can. The budget is a budget; Susan has applied numbers to what we've asked her to do. She has applied the best numbers she can. We can have a discussion on it, but I just can't imagine that somebody knows where we can get cheap catering or where we can get a bus for less money. Susan has the experience on this.

Now, this also talks about \$150,000 for consulting and professional research services, which is something we haven't landed on yet, we haven't agreed on yet, and we're not even sure if it's something that we're going to need. But in order to present a budget, we're going to have to come forward with some amount of money. Does this include the extra travel as well, Susan? The one we had before?

The Clerk of the Committee (Ms. Susan Sourial): Yes. So that's not in the subcommittee report—

The Chair (Mr. Kevin Daniel Flynn): Okay. So the budget you have before you also has an allowance for extra travel, should we decide that that's necessary, toward the end of 2009-10, but that travel is not scheduled yet, and unfortunately there's very little to compare this with. The other select committees have all been fairly different from ours.

Mrs. Liz Sandals: If we're going to visit First Nations—we're going to northwestern Ontario and northeastern Ontario and doing potentially more than three, plus doing some site visits in southern Ontario—is there enough in that northern Ontario budget, where the travel will be very expensive?

The Clerk of the Committee (Ms. Susan Sourial): The northern Ontario budget was based on visiting three First Nations communities. That's all it is. And it's not full committee—it's not Hansard and broadcast and recording. It's just the committee members, a chartered plane, hotel and meals. I didn't work in additional communities, if we were going to go elsewhere.

M^{me} France Gélinas: So the trip to Thunder Bay, Sudbury—I forgot—Thunder Bay, Sault Ste. Marie, is not in?

The Clerk of the Committee (Ms. Susan Sourial): I considered that central.

M^{me} France Gélinas: I feel special. I've never lived in central Ontario before.

The Chair (Mr. Kevin Daniel Flynn): You're moving either up or down in the world.

The Clerk of the Committee (Ms. Susan Sourial): So I budgeted for two trips to central and two trips to southern, if we added in another two weeks of travel in addition to what we're doing.

M^{me} France Gélinas: The one number that jumped out at me is, \$60,000 worth of advertising?

The Clerk of the Committee (Ms. Susan Sourial): One ad in one paper in the six communities or eight communities we're going to is \$30,000, and if we're going to travel a second time, that's a second set of advertising. Advertising is incredibly expensive.

M^{me} France Gélinas: To me, we have to look at this. Sixty thousand dollars is the budget for a mental health agency in my constituency, and I'm going to spend this on advertising? I don't think so.

The Chair (Mr. Kevin Daniel Flynn): Well, if the committee agrees—I wonder about the effectiveness, now, of newspaper advertising—we could do it ourselves, online, through groups, that type of thing. There seems to be an expectation that an ad gets run in the newspaper, but I don't think it's legislated. I don't think we have to do it. It's not mandated. You're right, it is a lot of money.

Mr. Bas Balkissoon: Can't we use the media to say we're coming and they'll print it for free?

The Clerk of the Committee (Ms. Susan Sourial): We can send out a news wire, but there's no guarantee that any paper will pick it up.

Mrs. Liz Sandals: And if you send out a news wire, they're not going to use it three weeks in advance, when we're trying to collect speakers. You're advertising the hearing, but the purpose of the ad is to let people in the local community know that you're coming to town and invite submissions.

The Clerk of the Committee (Ms. Susan Sourial): Another option, possibly, is to get MPPs in the communities that we're going to to promote it through word of mouth.

Ms. Sylvia Jones: My concern with that is we would get criticized for aiming for certain groups and certain organizations.

I'm looking at this budget and saying, boy, I really hope we do something with this report after we're done, because I don't want to have to stand there and say, yeah, I spent half a million dollars and we didn't do squat. I would hope that after this kind of investment—and it is an investment—to figure out where the opportunities are for improvement, we actually do something with it, because it would be a terrible shame.

The Chair (Mr. Kevin Daniel Flynn): Well, if there isn't anything—the advertising obviously jumps off the page, but it sounds like it's necessary.

The consulting and professional research services: We still haven't landed on that. We need to make an allowance for it, but that money may not be spent. The preparation of the report will probably be spent; that would be a portion of the \$150,000.

Once we've heard from the experts, we'll get a much better idea as to how much of that \$150,000 needs to be spent, but not to have it in the budget and to go back and ask for it—unless there's some huge disagreement here or something that people just can't live with, I'd suggest that we allow it to go forward. But if there are concerns, let's hear about them.

1730

Mrs. Christine Elliott: I would say we absolutely have to spend the money on the advertising, although I think it's an egregious amount of money. But if we want to have this as an open and transparent process and give particularly consumers and family members the oppor-

tunity to come and speak to us, I think we have no other choice but to do it.

As for the money that's budgeted for the assistance with human resources, \$150,000, we may well choose not to spend that. That's an upper limit. We may find that we only need somebody part-time to help us with report writing, but I think we have to allow for it because it's better we do that than to find out we're really under budget and have to go back.

The Clerk of the Committee (Ms. Susan Sourial): One thing I need to clarify as well is this budget is until March 31, 2010. We then have to go back to the board for April 1, 2010, to whenever the committee finishes, whether it's June or spring. So I did not put the translation and the printing of the report in this budget. It will be in another budget.

The Chair (Mr. Kevin Daniel Flynn): And unless we've missed something on this, unless we've made a gross error, which I'm pretty sure we haven't, you're right, Christine, this would be an up set limit. I just can't imagine that we could possibly spend any more than this. We've included two rounds of travel; we've included the researcher; we've included consulting professional services, advertising—really, everything is in here. So I can't imagine we'd be going back and asking for more; in fact, at the end of the day, I'd suspect we'll be taking money back to them.

Ms. Susan Swift: I just wanted to mention something about research service. Elaine Campbell was speaking to you last week, and she asked me to come this week in the event that you had any questions generally about the kinds of research services that we could provide to the committee.

Susan Sourial and I met in advance of this meeting to talk about the budget, and what we put in the budget included various options for the committee in terms of the kinds of research services they may need in addition to what we can provide to the committee. So, Susan, I think that we put into this budget an estimate on something along the lines of commissioning a study that the committee might want to have. We did that on the basis of the experience with the alternative fuels committee, where they commissioned a study from an expert consulting group on specific issues that the committee determined it needed expert advice on.

We also included an amount in the event that the research demands of the committee were so great that we couldn't meet those demands within our office itself. So an amount is in there if we had to hire another researcher for six months or eight months—something like that. So that amount is in there as well. Susan, what else is included in that \$150,000?

The Clerk of the Committee (Ms. Susan Sourial): Just those two.

Ms. Susan Swift: Just those two. So the committee may not need all of those services—

Ms. Helena Jaczek: What about the writing of that final report?

Ms. Susan Swift: If I can just speak to that. Typically, our researchers would write that report for the committee. They do it for every other standing committee, and we have been the primary support for every other select committee that has operated in the House.

We are not experts, certainly, by any means, and you will need to consult experts. There are various ways to consult experts, certainly, inviting expert panels to come. They have done that with the emergency management committee. They had an expert panel of lawyers and also labour experts come to speak to them.

But the writing of the report, the answering of the research questions as it goes on during the proceedings, we can do all of that. We can identify issues for you. We can do background papers. We won't lead the committee, obviously. You folks know where you want to go, but we'll follow closely behind, and we'll dedicate the resources that we can to serve the committee—absolutely.

The Chair (Mr. Kevin Daniel Flynn): Okay. Now is someone prepared to move this?

Mr. Bas Balkissoon: So moved.

The Chair (Mr. Kevin Daniel Flynn): So moved. Any speakers? You need to read it into the record.

Mr. Bas Balkissoon: You mean I've got to read the detail sheet line by line?

The Chair (Mr. Kevin Daniel Flynn): No, just this—just the motion.

Mr. Bas Balkissoon: I move that the budget of \$479,270 for the Select Committee on Mental Health and Addictions be approved, and that the Chair be authorized to present it to the Board of Internal Economy.

The Chair (Mr. Kevin Daniel Flynn): Any speakers? Seeing none, all those in favour? Those opposed? That motion is carried.

We have a letter from CAMH. Do you want the subcommittee to deal with that, maybe start to set up a tour?

M^{me} France Gélinas: Yes.

The Chair (Mr. Kevin Daniel Flynn): Okay, so that's agreed. We don't need a motion on that, just direction—that's fine. Of course, representatives from CAMH will be part of the experts.

Unless there's any other business, we are adjourned.

The committee adjourned at 1736.

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SELECT COMMITTEE ON MENTAL HEALTH AND ADDICTIONS

Chair / Président

Mr. Kevin Daniel Flynn (Oakville L)

Vice-Chair / Vice-Présidente

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Mr. Bas Balkissoon (Scarborough–Rouge River L)

Mrs. Christine Elliott (Whitby–Oshawa PC)

Mr. Kevin Daniel Flynn (Oakville L)

M^{me} France Gélinas (Nickel Belt ND)

Ms. Helena Jaczek (Oak Ridges–Markham L)

Ms. Sylvia Jones (Dufferin–Caledon PC)

Mr. Jeff Leal (Peterborough L)

Mrs. Liz Sandals (Guelph L)

Mrs. Maria Van Bommel (Lambton–Kent–Middlesex L)

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ISSN 1918-9613

**Legislative Assembly
of Ontario**

First Session, 39th Parliament

**Assemblée législative
de l'Ontario**

Première session, 39^e législature

**Official Report
of Debates
(Hansard)**

Wednesday 1 April 2009

**Journal
des débats
(Hansard)**

Mercredi 1^{er} avril 2009

**Select Committee on
Mental Health and Addictions**

Committee business

**Comité spécial de la santé
mentale et des dépendances**

Travaux du comité



Chair: Kevin Daniel Flynn
Clerk: Susan Sourial

Président : Kevin Daniel Flynn
Greffière : Susan Sourial

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Toronto ON M7A 1A2
Telephone 416-325-7400; fax 416-325-7430
Published by the Legislative Assembly of Ontario



Service du Journal des débats et d'interprétation
Salle 500, aile ouest, Édifice du Parlement
111, rue Wellesley ouest, Queen's Park
Toronto ON M7A 1A2
Téléphone, 416-325-7400; télécopieur, 416-325-7430
Publié par l'Assemblée législative de l'Ontario

LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

SELECT COMMITTEE ON
MENTAL HEALTH AND ADDICTIONSCOMITÉ SPÉCIAL DE LA SANTÉ
MENTALE ET DES DÉPENDANCES

Wednesday 1 April 2009

Mercredi 1^{er} avril 2009*The committee met at 1604 in committee room 1.*

SUBCOMMITTEE REPORTS

The Chair (Mr. Kevin Daniel Flynn): Thank you. Let's come to order. The clerk has advised me that we need to speak very clearly into the microphones. For some reason, they're having some problem with picking up everything that we're saying.

We have the agenda before you. The meeting is for the purposes of organization. To get us started, we need somebody to read into the record the subcommittee report dated March 10 and March 11, which is revised. Would anyone like to read that? That would be the first one.

Mrs. Van Bommel?

Mrs. Maria Van Bommel: The very top one here?

The Chair (Mr. Kevin Daniel Flynn): Yes.

Mrs. Maria Van Bommel: Summary of decisions made at the subcommittee on committee business.

Your subcommittee on committee business met on Tuesday, March 10, and Wednesday, March 11, 2009, to consider a work plan and a budget and recommends the following:

(1) That the committee clerk prepare a draft budget for presentation to the committee on Wednesday, March 25, 2009.

(2) That the committee invite representatives from the following ministries to appear before the committee: aboriginal affairs, Attorney General, children and youth services, citizenship and immigration, community and social services, community safety and correctional services, education, francophone affairs, health and long-term care, Ministry's Advisory Group on Mental Health and Addictions, health promotion, Ontario seniors' secretariat, municipal affairs and housing.

(3) That the committee invite as many expert witnesses as necessary to appear before the committee, including, but not limited to, Mr. Michael Wilson, Mr. Michael Kirby, Mr. Glen Thompson, Mr. Gordon Floyd, a representative of the Gerstein Centre, a representative of Parents for Children's Mental Health, a representative from the Durham Mental Health Services.

(4) That the committee schedule the ministry representatives and expert witnesses at its meetings on Wednesday, April 1, 8, 22, May 6, 13, 27 and June 3 and that the meetings be held from 4 p.m. to 6 p.m.

(5) That ministry representatives and expert witnesses be given 30 minutes to make presentations, including questions from the committee.

(6) That legislative research prepare a summary of all oral submissions (ministry, expert and public).

(7) That legislative research do a literature search regarding strategies for mental health and addictions in other jurisdictions, e.g. WOH and OECD.

(8) That, after hearing from the ministries and expert witnesses, the committee determine what more the committee needs and what form those needs should take (hiring of expert research, consultants, etc.).

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(9) That the committee clerk, with the authorization of the Chair, post information regarding the committee's business one day in the following area newspapers, in English and French newspapers where possible: Toronto, Windsor, St. Thomas, Hamilton, Kitchener, Thunder Bay, Sudbury, North Bay and Ottawa.

(10) That the committee clerk also post information regarding the committee's business on the Ontario parliamentary channel and on the committee's website.

(11) That interested people who wish to be considered to make an oral presentation should contact the committee clerk by 12 noon on Monday, May 11, 2009.

(12) That on Monday, May 11, 2009, the committee clerk provide the subcommittee members with an electronic list of all requests to appear.

(13) That, after the list of requests to appear has been distributed to the subcommittee, the subcommittee meet to determine certain aspects of the public hearings (presenters, times, duration of presentations etc.).

(14) That the committee hold public hearings the week of June 15, 2009, as follows: one day in Windsor, St. Thomas, Hamilton, and Kingston.

(15) That the committee hold public hearings the week of September 8, 2009, as follows: one day in Thunder Bay, Sudbury, North Bay and Ottawa.

(16) That the committee visit at least three First Nations communities the week of August 24, 2009.

(17) That the committee hold public hearings in Toronto in the fall of 2009 while the House is sitting.

(18) That the committee visit a treatment centre in the United States (Buffalo or Philadelphia).

(19) That the committee travel an additional two weeks in the November 2009-March 2010 period if required.

(20) That the committee clerk, in consultation with the Chair, be authorized, prior to the passage of the report of the subcommittee, to commence making any preliminary arrangements necessary to facilitate the committee's proceedings.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Mrs. Van Bommel. Speaking to the motion, M^{me} Gélinas, then Ms. Jones.

M^{me} France Gélinas: I noted two discrepancies. The first one is, at point 9, she mentioned Toronto, Windsor, St. Thomas, Hamilton, and she mentioned Kitchener. I think she meant to say "Kingston."

Mrs. Maria Van Bommel: Did I say "Kitchener"? I'm sorry. I saw "Kingston" and I said "Kitchener." I apologize.

M^{me} France Gélinas: The other one is a very small one. In point 7, when referring to the two examples, she referred to "WOH," when it's "WHO."

The Chair (Mr. Kevin Daniel Flynn): No problem. They will be corrected. Anything else, France?

M^{me} France Gélinas: No.

The Chair (Mr. Kevin Daniel Flynn): Ms. Jones?

Ms. Sylvia Jones: Just a question for the subcommittee: In point 11, "That interested people who wish to be considered to make an oral presentation should contact the committee clerk by 12 noon on Monday, May 11, 2009," is that for everyone who would like to appear up to and including the public hearings that are occurring in the fall of 2009, or would that be just for the week of June 15?

The Chair (Mr. Kevin Daniel Flynn): Good point. At the following subcommittee meeting, we realized that that was too early, really, for the people who are going to be appearing in the late summer or the fall period, so you'll see that that gets changed in the next minutes of the subcommittee, as point—what point is it?

Interjection.

The Chair (Mr. Kevin Daniel Flynn): That gets split up into points 7 and 8.

Ms. Sylvia Jones: Thank you.

The Chair (Mr. Kevin Daniel Flynn): So these are the changes that were made as a result of the discussion we had at the last meeting of the full committee, and since that date, the subcommittee has met again.

Are there any other points on the first set of minutes? If not, do I need somebody to move them?

Interjection.

The Chair (Mr. Kevin Daniel Flynn): Just carry it? Okay.

Let's go on, then. We need somebody to—I don't know if you have a sore throat or not now, after doing that, Maria.

Mrs. Maria Van Bommel: No, I'm good, as long as I don't get ahead of myself.

The Chair (Mr. Kevin Daniel Flynn): If you want to go on to the second one, there may be some discussion that arises from that.

Mrs. Maria Van Bommel: Someone will correct me if I get this wrong, so that's just fine.

Your subcommittee on committee business met on Monday, March 30, 2009, to consider a work plan and recommends the following:

(1) That committee meetings on Wednesday, April 8, 22, May 6, 13, 27 and June 3, 2009, be extended to 6:30 if required to accommodate the representatives from the ministries as well as expert witnesses.

(2) That the committee invite the following additional individuals or representatives from the following additional organizations as expert witnesses to appear before the committee:

—Centre for Addiction and Mental Health;

—Canadian Mental Health Association, Ontario branch;

—Ms. Cornelia Wieman, member, First Nations, Inuit and Métis Advisory Committee, MHCC;

—Dr. A.J. Cole, coordinator, Northern Ontario Francophone Psychiatric Program, Faculty of Medicine, University of Ottawa;

—Dr. Paula Goering, chair, Homelessness Research Initiative, MHCC.

(3) That the committee accept the invitation for a tour of the Centre for Addiction and Mental Health, and that the committee clerk make arrangements for the committee members to tour the facilities on Thursday, May 14, 2009, from 12 p.m. to 4 p.m., and that an alternate date for the tour of the Centre for Addiction and Mental Health be Thursday, May 28, 2009, from 12 p.m. to 4 p.m.

(4) That the committee clerk, with the authorization of the Chair, post information regarding the committee's business in two separate ads for the public hearings in June 2009 in Windsor, St. Thomas, Hamilton and Kingston; and the public hearings in September 2009 and the fall of 2009 in Toronto, Thunder Bay, Sudbury, North Bay and Ottawa.

(5) That the committee clerk send out a press release regarding the committee's business on CNW.

(6) That the committee clerk also post information regarding the committee's business on the Ontario parliamentary channel and on the committee's website.

(7) That interested people who wish to be considered to make an oral presentation in Windsor, St. Thomas, Hamilton and Kingston should contact the committee clerk by 12 noon on Monday, May 11, 2009.

(8) That interested people who wish to be considered to make an oral presentation in Toronto, Thunder Bay, Sudbury, North Bay and Ottawa should contact the committee clerk by 12 noon on Monday, August 10, 2009.

(9) That on Monday, May 11, 2009, and on Monday, August 10, 2009, the committee clerk provide the subcommittee members with an electronic list of all requests to appear.

(10) That after the list of requests to appear has been distributed to the subcommittee, the subcommittee meet to determine certain aspects of the public hearings (presenters, times, duration of presentations etc.).

(11) That the committee clerk, in consultation with the Chair, be authorized prior to the passage of the report of the subcommittee to commence making any preliminary

arrangements necessary to facilitate the committee's proceedings.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Mrs. Van Bommel.

Item 3: At the time that decision was discussed, we thought Thursday afternoons might work, and it appears that for perhaps a majority of members Thursday afternoons aren't going to work, unfortunately. So we probably need a bit more discussion on that.

Items 7 and 8: We'll probably clear up your suggestion, Sylvia, on the changes to the notification, so we may not have to discuss them.

On the first point, I think committee members would all agree that that is only if necessary. We put that down as we would meet until 6:30 "if required," but it wouldn't be a regular occurrence, and only if we needed to accommodate somebody the committee really wanted to hear from.

Why don't we open up with number 3, and perhaps see if we can't organize that tour. Bas, and then Liz.

Mr. Bas Balkissoon: We normally meet on Wednesday right now, and on Wednesdays the House doesn't start until 3. So if you just shift it to Wednesday, we can all go.

The Chair (Mr. Kevin Daniel Flynn): The problem is that with the number of people from CAMH that we've heard from, we're starting to realize that that's not going to be a one-hour tour.

Mr. Bas Balkissoon: But I mean we can go from noon until 4. The House starts at 3, and we'll get back here for 4. If there's a vote at 5 o'clock on that Wednesday, we'll be here on time. So Wednesday will work better.

The Chair (Mr. Kevin Daniel Flynn): Okay. As long as we're going to accommodate that much time in their schedule, that might work.

Mr. Bas Balkissoon: Yes, because on Wednesday we don't meet until 3 o'clock. I think that if we go on a Wednesday, it will be okay.

The Chair (Mr. Kevin Daniel Flynn): Okay. The other suggestion that was being made was a Monday morning. Liz?

Mrs. Liz Sandals: Yes. I'm fine with Monday morning, understanding that we wouldn't be back in time for question period. I'm okay with either.

Thursday the 28th is a total disaster for me. On the 14th, I think that four of us here are on House duty Thursday afternoon—five, counting you, Chair. The odds that we can get five subs on a Thursday afternoon are somewhere between slim and nil.

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The Chair (Mr. Kevin Daniel Flynn): If we decide that a Wednesday afternoon is preferable—

Interjection.

Mrs. Liz Sandals: Oh, we've got—okay. Let me think about this for a minute.

Interjection.

Mrs. Liz Sandals: Yes, once we go into report writing, at public accounts—what were the dates?

The Chair (Mr. Kevin Daniel Flynn): Okay, is there anybody—

Mrs. Liz Sandals: Just hang on, though, because depending on what we're doing, public accounts meets Wednesday morning and Wednesday afternoon. So the Wednesday doesn't meet if we're doing public hearings.

The Chair (Mr. Kevin Daniel Flynn): Let's go on to Sylvia, and then we can come back to you, Liz.

Ms. Sylvia Jones: My preference would be Wednesday afternoon for sure, whether that starts at 4 o'clock or a noon tour—

Mr. Bas Balkissoon: We'd start at 12:30.

Ms. Sylvia Jones: Well, yes.

The Clerk of the Committee (Ms. Susan Sourial): Can I just say that we spoke to CAMH, and they said to allow at least three hours for the tour.

Mr. Bas Balkissoon: So 12:30 to 3:30?

The Chair (Mr. Kevin Daniel Flynn): France, from your schedule with your party, does it—

M^{me} France Gélinas: I'm also on public accounts, but if it's not something that has to do with health, then I would ask somebody else to sub in for me on public accounts on Wednesday. So I could make myself available starting at noon on Wednesday. I don't have the schedule for public accounts right now, but as soon as I have it, I can let you know which Wednesday I would be free.

The Chair (Mr. Kevin Daniel Flynn): Okay, so Wednesday afternoon would work for everybody if we could sort out public accounts. Liz, can we find a date when we know that public accounts is not meeting?

Mrs. Liz Sandals: I think that, as of May 27, we will only be meeting in the morning. So on May 27 and the following week in June, it looks to me like public accounts will only be meeting from 9 to 10:30, so the public accounts committee members would be free from 12:30 to 3:30 or 12 to 4.

The Chair (Mr. Kevin Daniel Flynn): May 27 would work for me. June 3: Is there any reason—

Interjection.

The Chair (Mr. Kevin Daniel Flynn): June 3 is the day before the House rises. Does that present any issues for anybody?

Mrs. Liz Sandals: It means it's more likely there will be votes that are sort of randomly all over the place.

M^{me} France Gélinas: So May 27 would be better.

The Chair (Mr. Kevin Daniel Flynn): Okay, let's aim for May 27, with June 3 as our backup date, but our preference being May 27. We'll amend item 3. Would you move that, Liz?

Mrs. Liz Sandals: Yes.

The Chair (Mr. Kevin Daniel Flynn): Okay, are there any other points here? Christine, you went through it. You're good with everything? I don't think there was anything that really deviated from what we were thinking of doing.

France, anything?

M^{me} France Gélinas: I remember a suggestion being made. I forget what it's called, but it had to do with

sending a media advisory where it was a question of \$200, and that would send it everywhere. I didn't find this in number 5.

Interjection.

M^{me} France Gélinas: That's what you were talking about before? What does CNW stand for?

The Clerk of the Committee (Ms. Susan Sourial): Canada NewsWire.

M^{me} France Gélinas: Sorry, I didn't recognize it. Thank you.

The Chair (Mr. Kevin Daniel Flynn): Any other points?

Ms. Helena Jaczek: I'm not sure if it really is appropriate here, but in relation to our list of individuals, we did have some discussion last time about looking into who the stakeholders of the various ministries were, and I did get a list from the Ministry of Health Promotion of who they formally consider their stakeholders. I don't know if we want to add them now or if we're just going to invite them anyway. But in addition to CAMH and the Canadian Mental Health Association, who we have on the list, they have the Ontario Public Health Association and the U of T Centre for Health Promotion as also considered stakeholders.

The Chair (Mr. Kevin Daniel Flynn): What we did, just so you understand, Helena, is we went through the list that was provided by research, which was quite an extensive list, and we realized, with the amount of the time we had available to us between now and the break and the advent of summer, that we could only see a certain number of people. We fully anticipate expanding this list, but this gets us through this term to the start of the summer, and these will be the people who will have been invited to date, but certainly we should include those people on the next list.

Ms. Helena Jaczek: I didn't see them on the research lists, so I did double-check. I could perhaps forward those to you.

The Chair (Mr. Kevin Daniel Flynn): We fully anticipate we'll be hearing from a lot more people. We

just heard today that Senator Kirby has accepted our invitation to appear in May—

Interjection.

The Chair (Mr. Kevin Daniel Flynn): Oh, and we think it's May 27, which actually could be timely, right? if we're meeting at 4?

M^{me} France Gélinas: Yes. We could be back for 4.

The Chair (Mr. Kevin Daniel Flynn): It probably ties right in. It will be a good afternoon's worth of mental health.

M^{me} France Gélinas: Maybe tell him to come at 4:30 just in case.

Mrs. Liz Sandals: Tell him 4:30. Don't book it. That day it would not be good to book anybody at—

The Clerk of the Committee (Ms. Susan Sourial): think it's 5.

The Chair (Mr. Kevin Daniel Flynn): Is it 5? That will work out fine.

Mrs. Liz Sandals: It would probably not be good to book at 4.

The Chair (Mr. Kevin Daniel Flynn): France?

M^{me} France Gélinas: I know I'm the one who was aghast at the price of advertising, but I would ask the indulgence of the committee that not only do we advertise in Thunder Bay, Sudbury and North Bay, where we will have hearings, but in Timmins also. Although we won't be going to Timmins, I know there's very high interest in the Timmins-Cochrane area, all the way up the James Bay coast. If we could advertise in the Timmins daily—I don't know the name of it, but I know that there's a paper out there.

The Chair (Mr. Kevin Daniel Flynn): Okay. Any issues with that? No?

Okay, all those in favour of the minutes from your subcommittee, as amended? Opposed? That is carried.

Any other business? Seeing none, we're adjourned. Thank you very much. We can get going now.

The committee adjourned at 1625.

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ISSN 1918-9613

Legislative Assembly of Ontario

First Session, 39th Parliament

Official Report of Debates (Hansard)

Wednesday 8 April 2009

Select Committee on Mental Health and Addictions

Mental health and addictions
strategy

Assemblée législative de l'Ontario

Première session, 39^e législature

Journal des débats (Hansard)

Mercredi 8 avril 2009

Comité spécial de la santé mentale et des dépendances

Stratégie sur la santé mentale et
les dépendances



Chair: Kevin Daniel Flynn
Clerk: Susan Sourial

Président : Kevin Daniel Flynn
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Telephone 416-325-7400; fax 416-325-7430
Published by the Legislative Assembly of Ontario



Service du Journal des débats et d'interprétation
Salle 500, aile ouest, Édifice du Parlement
111, rue Wellesley ouest, Queen's Park
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Téléphone, 416-325-7400; télécopieur, 416-325-7430
Publié par l'Assemblée législative de l'Ontario

SELECT COMMITTEE ON MENTAL HEALTH AND ADDICTIONS

COMITÉ SPÉCIAL DE LA SANTÉ MENTALE ET DES DÉPENDANCES

Wednesday 8 April 2009

Mercredi 8 avril 2009

The committee met at 1605 in committee room 1.

MENTAL HEALTH AND ADDICTIONS STRATEGY

The Chair (Mr. Kevin Daniel Flynn): Ladies and gentlemen, if we could all take our seats, we can call the committee to order.

Committee members will have something in front of them that is information on some things that have been happening in the Fredericton area of New Brunswick, something that came across my desk from somebody who wanted us to know that.

Today is the first time we're hearing from some members of the public. We're hearing from the experts in the field first, people who have a more-than-intimate knowledge of the current shape of mental health and addiction services in the province.

PARENTS FOR CHILDREN'S MENTAL HEALTH

The Chair (Mr. Kevin Daniel Flynn): Today, we have with us Parents for Children's Mental Health. We've got Sylvia Naumovski, Sarah Cannon and Sean Quigley. Please come forward.

As I said when I came in, you're our guinea pigs; you're our first. We're experimenting with you here today. The committee met previously and decided that the rules would be that each delegation would get 30 minutes. If you want to leave a little bit of time in there for any questions from the committee, that would be wonderful. You're the only delegation today, so you may get a little bit of latitude from the Chair, but if you could keep it around that time, it would sincerely be appreciated. The floor is yours.

Ms. Sarah Cannon: I think we can probably do that and keep it very concise.

The Chair (Mr. Kevin Daniel Flynn): Just before you start, please identify yourself for Hansard so we can get it in the official record.

Ms. Sarah Cannon: I'm Sarah Cannon.

I think we want to present to you the information that you want to hear, so I think it's more important for us to answer your questions, but we will give you a little bit of background.

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We have met with a lot of you in person, so we have been able to share some of our personal stories with you, but Parents for Children's Mental Health is a non-profit provincial organization. Our mandate and our goals are to educate, empower and support families and their children who struggle with the daily, unique challenges of having children with mental health issues.

All of us involved with Parents for Children's Mental Health are families; it's a family-driven organization. We all have children who have mental health issues. So we're coming at this from a very personal perspective, and that's really important to families, because one of the biggest problems there is surrounding the issues of mental health, especially children's mental health, is the stigma, isolation and discrimination that families feel.

I think one of the main things that we're trying to promote, especially to this committee, is that we are the true front-line workers with our children. Parents are an untapped resource when you are dealing with the crisis of the mental health system, and we are offering our expertise and collaboration with you, with the government, with our agencies, because there is a huge need to fill in these gaps and the deficits in our system that are seriously affecting our lives. We're very willing to step up to the plate, offer our assistance and offer to be resources. We come at it with a lens that no one else can offer and which isn't taught in curriculum, and that is that we can tell you precisely how these issues translate in real life, in real time, and what the outcomes are of some of the serious deficits of our system.

I don't think I need to list what all of the deficits of our system are. One of our comments is that there have been numerous, numerous reports, especially recently, about what all of the deficits are in the mental health system. This is not a new issue. This has been going on for decades.

I think the point has come that we as parents are saying, "Enough." We have asked nicely, and now we're sort of demanding that our voices are heard. We're three, but we're representing hundreds and thousands of families. Currently there are 654,000 families in this province who are dealing with this. That's unacceptable.

This morning, I was looking at an old report of the mental health implementation task force that was established in 2000. The report that they put forward is called *The Time is Now*. That was nine years ago. My personal

request of this committee—and after meeting with most of you, we recognize that we do have some true champions here, but we would like to see action and a plan. We don't want just another report that, nine years from now, we're going to be referring to, that says the same thing we've been saying decade after decade. We need parity, we need equity, and we need our children and our families to be treated respectfully by the system.

I think that sums it up. We'd like to take your questions because we really want to give you the information that you need, we want to give you our perspective, but we want to give you the perspective in the areas that you want to hear it and that you're prepared to discuss and put into action.

The Chair (Mr. Kevin Daniel Flynn): Wonderful. Thank you very much for your comments. Why don't we give 10 minutes to each of the parties, maybe starting with Christine and Sylvia, and just go around?

Mrs. Christine Elliott: Sure. I know we've talked about some of the issues, but if you could—there's a stigma issue that's still associated that we need to be dealing with and, of course, there's just the under-resourcing of children's mental health services that we've talked about. Could you give us sort of the top three priorities perhaps, Sarah, in terms of what you would like to see addressed immediately, and then perhaps what could be more of a long-term strategy?

Ms. Sarah Cannon: Stigma is definitely the number one thing for me, personally. I don't know if you might want to ask all of us what our top three are, because that's something that might not be consistent.

But for me, it's stigma. I truly believe that that's sort of at the heart of what is wrong, because there isn't a big enough public outcry about what's going on. I really, truly believe that a lot of that has to do with the stigma of it. So, yes, for me, that's a huge thing.

The other thing for me, personally, is the number of ministries that are involved and the way that translates in my life. It is indicative of what a lot of families go through. Our children go to school; they have mental health issues while they're in school; schools are not resourced to help them. My child goes into a crisis; I'm told to go to the hospital with my child; I get to the hospital and they don't have the resources to help. My child needs service acutely because they have a mental health issue; our child and youth agencies are so overburdened that they don't have the capacity to help me. So I would like to see a defragmented system and an inter-ministerial collaboration.

Third, I want to see equity not only in funding, but in the approach that the government, the public and everybody takes. When I go to the hospital with my child, I want my child's mental health issues to be as serious and as important to that hospital as if they had a physical health issue. I want every discussion around my child's mental health to have that parity and that equity with their physical health.

Those would be my three.

And I want my child and youth workers recognized for what they do, because they're the ones who are saving my daughter's life.

Ms. Sylvia Naumovski: I'd like to see a bigger concentration on prevention and early intervention; the reason being, in prevention, we have to have—

The Chair (Mr. Kevin Daniel Flynn): Excuse me, Sylvia, I know you're on a roll, but could you identify yourself as well? Sean, when your turn comes around, could you do the same? Thanks.

Ms. Sylvia Naumovski: Sorry, it's Sylvia Naumovski. Where was I?

Ms. Sarah Cannon: Early intervention.

Ms. Sylvia Naumovski: Prevention and early intervention.

I truly believe that we're going to have to look differently and work in that mode, that we have to look at prevention, and that we've got to educate the whole public. We're going to have to go into the schools so that we can touch not only the children, but the adults, because everybody is affected by mental illness. It may not be when they're five or seven because they have ADHD, but maybe they'll have a life-threatening thing that happens to them when they're 13. Why are we waiting to help these people? Why don't we have a program that's put into place early so that it becomes part of the norm, and so the prevention component is there, and then everybody knows what is expected?

When I talk about early intervention, it also has to be taken early at the kids' level. We don't want it to be that the child is in crisis. We want him to be caught before he gets in crisis. What's happening now is children who are 14 have something happen to them and they're in crisis and they have to wait eight months for help. So what happens is that things get worse and worse. It gets deferred, they break the law, become homeless. We could eliminate some of this if we just intervened early.

Mr. Sean Quigley: Sean Quigley.

A couple of things are really key. The first one is to recognize that it's not enough to recognize that there's an issue. Everyone around the table here recognizes that there's an issue. That's why we're here.

We had a meeting earlier with MPP Gélinas, and I was telling her the story—I was sitting outside in the park, and I was looking across here at the building, and I said that I'm not really feeling the love. These families, my family, my daughter, and the thousands of families across the province need to feel the love, the love being in terms of how children's mental health is funded, which we know hasn't happened for the last 14 years. There has been no increase, and that needs to change as far as services go.

We know that if there are peer-supported programs, they are really effective. There is study after study in the United States and in Canada that back this up.

We're here to offer our help to you. My goal is to get you all to succeed, and in order to do that, we have to have a conversation. The conversation is about how somebody like myself, who's an expert when it comes to

my child and her care, can give you information that will help you make decisions. The bit of information that I want to give you is to recognize that we families are experts in this care. We have dealt with a number of ministries and a number of programs: health, education, justice, child and youth. It goes on and on. From dealing with all of those different departments, we bring to you a unique perspective that is not easy to duplicate by talking to one agency or even the largest agencies in the province.

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The next thing I want to say to you is that talking about community and engagement is a very interesting concept. What does engagement mean? From my point of view, engagement means that right now you're doing it; you're talking to us and asking for our input. That's great. But engagement also means that when you come to make recommendations, you talk to us before putting those recommendations out, in order to get our input on those recommendations. When you make those recommendations, you ask us to be a part of their implementation, and then when you implement those recommendations, you ask us to be a part of how those implementations get put into place. That is engagement, and because these problems will only be solved through community and we are leaders in our community when it comes to child and youth mental health, we're good people to tap into, and we want to help you.

That's what I would say is really critical here. We need to deal with the funding issue. It's the elephant in the room that needs to be sorted out. You need to deal with how people are engaged and you need to recognize the expertise that has come about from some fairly hard-won struggles. Our stories—a number of you have heard them—are not unique; they are commonplace. That is a sad, sad thing.

The Chair (Mr. Kevin Daniel Flynn): One short question left. I think we've got about a minute or two.

Ms. Sylvia Jones: I'm not sure if it's a short question, but it will be a short question; you decide with the answer—

The Chair (Mr. Kevin Daniel Flynn): It'll be a short question, long answer.

Ms. Sylvia Jones: I am interested in your experience, as an organization, in dealing with the magic age, 18, consent and families, because you're talking a lot about how families are so important to the care, but I need to know what happens at 18 and what your group has been doing for that.

Ms. Sylvia Naumovski: My name is Sylvia Naumovski. The care doesn't continue on, and it is a big concern because children grow up. A lot of times, children suffer from psychiatric problems later in their teens, so when they finally do get service—let's say they're 16 and they wait eight months, so they're 17 and get serviced. They're almost 18 and have to move into the adult system. There's no continuity. My son is actually going through that right now. There are no programs particularly for that age group. What I think happens is a lot

of them go homeless because the parents can no longer deal with them at home, because a lot of them become dangerous—I'm talking about some young kids—and the advice that I got was to lock my doors.

Ms. Sylvia Jones: Even with families and parents who want to continue—

Ms. Sylvia Naumovski: There's no place for them to go, and then if you do find a place, it probably costs a lot.

Also, I think parents are exhausted. They also say, "Well, he's 18 now; maybe it's time that he's on his own," and what ends up happening? The child cannot cope. He hasn't learned coping skills and he ends up going on the street.

This is something we were talking with France about. We really have to think about a different approach, and maybe family-driven care or family-centered care might be the way to go. We've got to think of a different way. Parents need to be trained, or they can help out the system by having training. Funding needs to go towards them so that they can at least provide other sources for them, or housing. If the child can't live with you, at least you can put them in a safe place and help subsidize, instead of just dumping them. They need assistance. Parents can provide policies and advice on policies.

The Chair (Mr. Kevin Daniel Flynn): Actually, I'm going to move on to the questioner, but I'm sure you can continue on that train of thought in your answer.

Ms. Sylvia Naumovski: That's fine.

The Chair (Mr. Kevin Daniel Flynn): France, you're next.

M^{me} France Gélinas: No, I would encourage you to continue. I know that we've had conversations and not everybody had an opportunity to hear, but certainly, if you want to continue on some of the ideas you've shared with me toward family-centred care and how an organization like yours could make a difference in children with mental health.

Ms. Sylvia Naumovski: The two main things for mental illness are loneliness and not being connected. So what do you have to do? You have to change that. You have to make someone who suffers from mental illness feel connected, loved and not lonely. In my situation, my son is aggressive and threatens to kill me. I can't live with him. I put him in an apartment all by himself with practically nothing. All he wants to do is come home, but I can't have him at home. He's a risk. He threatens me and my family, so he sits in his apartment. He is miserable. We had him come home just for a very short period of time. He went from here up to here, and I felt so bad. I am doing exactly what is not helping him. He needs to feel connected. He's lonely.

Mr. Sean Quigley: This idea of feeling connected goes to a concept that many of you will have heard and will definitely hear in your consultations: the idea of resiliency. Resiliency is the ability to overcome a crisis quickly and move past it. Resiliency also refers to your ability to be connected to the community and feel supported. That's a critical component when we're talking about family-centred care. Sylvia's case is exactly

that. Because her son isn't connected to a community of care, a continuum of care, there is no resiliency, so the same issues come up again and again and again.

Ms. Sarah Cannon: We need to—very briefly, I'll tell you—have the services wrap around the families, not the families travelling all over the place, to different places trying to get service. The family needs to be treated as a whole and the services need to treat the whole family, because with an increased capacity to deal with it as a family, that child at the centre of that is going to have an increased capacity to overcome it. We're not just talking about the child affected; we're talking about the mom, the dad, the siblings, the grandmas, the grandpas, the aunts and uncles, and everybody in their lives—their teachers. Let us feel wrapped around.

The Chair (Mr. Kevin Daniel Flynn): France?

M^{me} France Gélinas: I know that it will be a repeat, but I think it's worth saying: You've all had experience with a child who had mental health issues, but in your own way, all of you were able to succeed, in some form or another, where lots of other parents have failed. I wondered, if you're comfortable, if you could share some of your personal stories and some of the key—not decision points, but some of the key activities that really shaped the treatment for your sons and daughters, and where the system actually worked for you.

Ms. Sylvia Naumovski: I feel that I cheated because—Sylvia Naumovski.

The Chair (Mr. Kevin Daniel Flynn): Actually, you don't have to introduce yourself every time.

Interjections.

Ms. Sylvia Naumovski: Okay. In a sense, when I'm saying I feel like I'm cheating—I took everything; I knew everybody; I would tell everybody; I would go to everybody. I would phone my mother's friend who was a principal and somebody who was a psychiatrist and ask them for their help—for my personal gain, to help my son—but that isn't how it should be. I speak English and I had connections to a few things. I beat on the door. I phoned every single person. I went through the directory and I learned lots, and that's how I did it. But a lot of people can't do it that way. I was persistent and I would keep on calling and I would keep on—I had said, "He is in crisis, he is in crisis, he is in crisis—you have to take him. He just has to be taken." I'd phone every single day. Well, he just got worse, and so, finally, they did take him, but that's how it worked, and I just kept on, for whatever it was—school or whatever; it was just persistence, persistence, persistence.

M^{me} France Gélinas: But your son also participated in a program that you ended up having to pay for yourself.

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Ms. Sylvia Naumovski: Yes. Unfortunately, he had oppositional defiant behaviour. Of course there's no buy-in, and every time you went to a program—there were programs offered—and he didn't want to do it, well, forget it: Out he goes. So we would keep on trying different programs.

He actually broke the law and was in jail. He had a choice: Stay in jail or his parents are going to send him to Project DARE, which was up in the north, where he's in complete isolation. He loved it, though. It was the best thing, but it was probably because he was there at a certain time in his life. His other choice was jail; what would you pick?

He got a lot out of it, but the sad part—well, for us—was we financially had to support it. There's no financial support like OHIP or anything like that, there's no other program within the province that I know of, and it cost us a lot of money. We were only able to keep him in for seven months. When he came out, there was no follow-up. He just reverted to drugs and everything else. It was good at the time, but if the program could have continued it would have been even better, and that's kind of sad. There are programs there, and excellent programs, but there's not the continuity to continue it on to help someone to succeed.

Ms. Sarah Cannon: Sylvia's not telling you what constitutes "a lot of money," but for seven months, that was \$60,000. How many parents and constituents can you think about who could just hand over \$60,000 for seven months? That's an issue.

Mr. Sean Quigley: With our child, my daughter, Erynn, the reason we're successful is my wife and I are fortunate. We're fortunate in that we're well-educated, we're fortunate in that we have a good livelihood, and we're fortunate in that we live in a good neighbourhood, so we're able to stand up for ourselves. But also, on top of that, we had to keep calling and knocking and calling and knocking. Persistence was key, and not being willing to just, as I say, sit in the bunker. The bunker is where we were when we were feeling cut off, unsupported, and we were days away from selling our house. We decided we're not going to do that; we're going to stand up and actually start to fight and advocate for ourselves.

It wasn't until that happened that things changed for us, and our daughter—respite care was critical for our daughter. It gave us the space. I would be called every day at school to pick her up from school. She'd arrive at school at 9, I'd be picking her up at quarter after 9, no exaggeration, four out of five days. Your job is affected by that, obviously.

Also, the fact is that we finally got to a point where we were so pushy that we got what we wanted: The squeaky wheel gets the oil, yes? That's what it takes. But I've said to a number of you—and I know Sarah and Sylvia have said this—what about the single mom who works in a call centre for \$10 an hour and has two kids, one child has a mental health issue, and she's trying to live on something like less than \$1,300 a month? How does that parent advocate for themselves that way?

The good news is my daughter is now in grade 7, she's on student council, and she's got the highest academic grades in the school. That's good news. But as many people in the agencies tell me, and I believe them, we're the exception; we are not the commonplace.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Sean. Thank you, France. The government side: Helena?

Ms. Helena Jaczek: Yes, I'd just like to explore a little bit more the early intervention that I think, Sylvia, you mentioned—and Sean, perhaps you got some early intervention in your case. What is the problem there? Presumably—and I'm just speculating, so I'd like you to tell me, but I'm wondering, is it that the parent sees something is wrong, approaches a health professional perhaps, a family doctor? I don't know how this happens. Is there a recognition issue in terms of not acknowledging, not being able to diagnose, not being able to really understand what's happening? Is there an education issue here that people need to actually understand how to recognize? Is that part of it?

Ms. Sarah Cannon: I'm going to try and answer all that. "Yes" is the short answer. I think there are a couple of really important elements that we need to make you understand. One of the deficits, when you know that there's something wrong with your child, if it's a mental health issue, is, first of all you're not educated. Mental health issues aren't well publicized, and no parent is going out thinking, "Oh, I think my kid has a mental health issue." That's not your first, knee-jerk reaction. You're noticing something's wrong but your mind doesn't go, "Psychiatric." You get there, but even once you get there—if you're lucky enough to get there, which takes years for a lot of families to do; not months, years. In my daughter's case it took years, and it wasn't until there was a witnessed psychotic break that the doctor went, "Oh, yeah. Maybe we're talking about a psychiatric thing," even though I'd been describing it for months and months.

Even once I was like, "Phew. Somebody's listening to me and now we're going to get help," no, that's not how it works. A social service worker is sent to my house. A social service worker spends maybe six hours a week with me for six weeks watching how I interact with my daughter, watching how she interacts with me, how she plays, how I discipline her. She talks to me about how to effectively listen to my child, how to positive-parent. I was sent to 1-2-3 Magic classes. I was sent to three different parenting classes that I had to go to. Then the social workers write up their report and go, "Mom's okay. She's not the one causing the problems. Now we need to turn our attention to the daughter." Okay, yes, we've recognized that the daughter needs help, so now I'm put on a wait-list to talk to an administrator who is going to decide where I go. So for six weeks I wait to have a phone interview. Then I have a phone interview with someone who's checking off boxes and says to me, "No, I don't think this is appropriate for you. You need to go here." And this is the cycle: six weeks, six weeks, six weeks, and then even when you find the box-checker who says, "Yes, you fit, but we're going to see you in eight months, okay?"

The way I like to illustrate this is if we take this and I now have walked into my doctor's office and my child is diabetic, I am not being sent to nutrition classes, cooking

classes, calorie-counting classes and proper exercise. I don't learn all of that before they look at my daughter and treat my daughter and give her insulin. They don't say to me, "In eight months we'll give her insulin. Hopefully she doesn't go into a diabetic coma before then. If she does, make sure you hurry up and get to the hospital." So that is a key problem.

Do I know all the answers to why that happened? No, but that's how it plays out. I don't believe there's an awful lot of education. Even within our doctors' education system, I don't think they're trained properly in how to recognize it. Even the professionals and doctors who work in that system are stigmatized against, so people don't generally go there immediately. Logically, that makes sense to me, because 10 child psychiatrists a year are produced in Canada. How's that? Obviously doctors aren't going, "Woo, I want to be a child psychiatrist," and I think that's because they're low on the totem pole.

So it is a big cycle that has more than one element for sure, but I think the biggest part of it is, they look at it completely backwards. The parents are meant to go through all of these hoops and we're put under a microscope and we have to prove this isn't our fault. And when we've done that, then they'll go, "Okay. We're going to try now to fix your kid."

The Chair (Mr. Kevin Daniel Flynn): Thank you. Just a brief answer, and then we'll go on to Liz.

Ms. Sylvia Naumovski: Oh yes, it'll be brief. For early intervention, I think that it really has to be a prevention thing. In the schools, teachers have to be trained—they're not trained—so they can recognize it and pass it on to the parents. They don't just teach children; they teach the parents, and then the parents will have to go to whoever after that. So I think it has to start at a prevention level at an early age. For the other situations where a child is 14, before he gets into a crisis, early intervention before a crisis—basically money has to go to the service providers to help those families. That's the only way it's going to help, because they're in crisis. There's no other way it can be done, because they cannot do it themselves.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Sylvia. Liz?

Mrs. Liz Sandals: That was actually where I was headed anyway because Sarah had mentioned prevention and early intervention. I wanted to know, and perhaps you can flesh it out a little bit more, what you think prevention looks like, because people mean a whole lot of different things by "prevention," and I'm never quite sure what they mean, so I'd like you to flesh it out.

Ms. Sarah Cannon: I personally don't like that. Sylvia and I debate about this.

Mrs. Liz Sandals: That's why I'm asking, because I bet you don't actually agree.

Ms. Sarah Cannon: For me, "prevention" implies there is something I could have done to stop the fact that my child had a mental health disorder. I agree that we have to prevent the crisis. I'll let Sylvia flesh it out.

Ms. Sylvia Naumovski: For me, "prevention" is that you look at the whole society, and you've got to teach the whole, not just a little part. I truly believe that everybody's affected by mental illness, so we have to be able to make them aware and educated so that they can see the signs and go for help. We also have to have anti-stigma campaigns so people don't feel ashamed.

Mrs. Liz Sandals: So is it really so much prevention as early recognition, which is slightly different than early intervention?

Ms. Sylvia Naumovski: That's true; there's a combination. "Prevention," I guess, would be a healthy society, but making sure they are kept healthy.

Mr. Sean Quigley: I want to steer you away from the idea of prevention. I want to talk about mental wellness instead. Mental wellness is where you set up a system within the schools, within organizations and in the workplace where the people within those groups feel like they are supported and that it's okay for them to go through a crisis and they know they'll be supported, in whatever form. That could be a mild depression, or it could be that my grandmother passed away and I need some time to deal with that grieving.

There is successful model after successful model when it comes to mental wellness across the world. New Zealand has a very successful model. Northern Ireland has built one. Great Britain has built one. The European Union has built one. We know that the idea of mental wellness is really important.

Where it was most effective, if you're talking about early intervention, is in the primary schools. You talk about mental health and wellness in the primary schools, and that leads to a word I discussed earlier, which was resiliency, and community. Those programs reinforce those ideas amongst the whole school. It's learned at a young age, and by osmosis, the parents in the community will hear about that, just as I hear about my daughter's adventures in her physics class. There will be an osmosis. Then you bring that out into the community.

I've said to a couple of you that if you're going to talk about educating, dealing with the stigma and how to present a message to the public, you shouldn't be looking at your standard PSA: "Let's all do this"; you should be taking a page from Coca-Cola. Coca-Cola markets really well. They hook in the young kids, they hook in the middle kids, they hook in us adults, and they hook people from all over the world. Coca-Cola is good at marketing. Take a page from their book when it comes to dealing with the idea of marketing against mental health stigma.

The Chair (Mr. Kevin Daniel Flynn): You still have a couple of minutes if there are any final words.

Ms. Sarah Cannon: I would like to add something around early intervention because, like you said, there are a lot of different connotations and ways that it can be interpreted. For me, what strikes me about this system is the fact that it is a worst-come, first-served basis. Because of the increasing burdens that are placed on our system, the criteria for "worst" are becoming worse and worse and worse. You almost have to be going in there

bleeding for them to say, "Okay, yeah, we need to deal with you."

For me, early intervention and prevention is, let's start to back that circle up, give our services the supports and our families the capacity so that we can intervene before it's a crisis, before our kids are going to the hospital suicidal, before moms are finding their teenagers on the floor. I think it depends on which point in time you want to look at it from, if we're talking about acutely right now or how you want it to look in the future.

Ideally, what Sean says: I think about how absolutely adamant my kids are about recycling and energy prevention. If they walk by me in the morning and I'm brushing my teeth and the water is running, they turn it off and yell at me because it is drilled into their head at school—if I don't put my can in the right recycling box. It's possible. Let's start. Those kids are sponges and they're going to deliver that message for us.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for appearing before us today. I think you said in your opening remarks that you sensed that there may be some champions sitting around the table. I think you're absolutely right on that. This is the first time on a select committee for all of us, I believe, the first time going through this process. We're going to be hearing from an awful lot of people in the field. Some of those people we haven't heard from yet, obviously, we haven't been exposed to, but from what you've said today, I think we probably started with the right group.

Ms. Sylvia Naumovski: Thank you.

The Chair (Mr. Kevin Daniel Flynn): I think some of the comments you gave us will give us something to set that standard by because you're living this daily, aren't you?

Ms. Sarah Cannon: Yes.

Mr. Sean Quigley: Yeah, we are.

Ms. Sarah Cannon: I know that this committee is going to be travelling, and you've heard from three of us, but make your own commitment as a committee as you travel to try to listen to families everywhere that you're going—and youth, because youth have an even different perspective and spin on things than we do. They truly are the product of what they're living.

I'd also like to offer if we can try to get responses for you through e-consultation or whatever, asking pertinent questions of our parent membership, polls or whatever—we have polls on our website—if you want that kind of information gathered, then we'd like to offer that to the committee as well when you're looking at things from the true family perspective.

The Chair (Mr. Kevin Daniel Flynn): That's wonderful. Thank you very much for your attendance.

Members of the committee, we do have a full slate. Our next meeting is completely booked, and that will be two weeks from now. Next week is constituency week, and then the week after that, we have a full slate. We're adjourned.

The committee adjourned at 1644.

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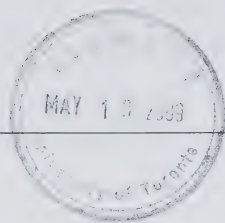
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ISSN 1918-9613

Legislative Assembly of Ontario

First Session, 39th Parliament

Assemblée législative de l'Ontario

Première session, 39^e législature

Official Report of Debates (Hansard)

Wednesday 22 April 2009

Journal des débats (Hansard)

Mercredi 22 avril 2009

Select Committee on Mental Health and Addictions

Mental health
and addictions strategy

Comité spécial de la santé mentale et des dépendances

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Telephone 416-325-7400; fax 416-325-7430
Published by the Legislative Assembly of Ontario



Service du Journal des débats et d'interprétation
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Téléphone, 416-325-7400; télécopieur, 416-325-7430
Publié par l'Assemblée législative de l'Ontario

LEGISLATIVE ASSEMBLY OF ONTARIO

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SELECT COMMITTEE ON
MENTAL HEALTH AND ADDICTIONSCOMITÉ SPÉCIAL DE LA SANTÉ
MENTALE ET DES DÉPENDANCES

Wednesday 22 April 2009

Mercredi 22 avril 2009

*The committee met at 1605 in committee room 1.*MENTAL HEALTH
AND ADDICTIONS STRATEGY

The Chair (Mr. Kevin Daniel Flynn): Okay, ladies and gentlemen, if we can call to order. We're a few minutes past 4 o'clock.

I just want to draw the committee members' attention to a very nice thank-you letter from the Parents for Children's Mental Health, whom we heard from at our last meeting, and some information that's also before you. It's background on mental wellness initiatives that has been prepared by our research folks for your consideration. When we get to 6 o'clock, we'll be dealing with a letter that has come to us from the Auditor General to get some opinions from the committee.

MINISTRY OF THE ATTORNEY GENERAL

The Chair (Mr. Kevin Daniel Flynn): Right now, we're going to hear from our first delegation, the Ministry of the Attorney General. We've got Curt Flanagan with us today, director of mental health, criminal law division.

Curt, please come forward. Make yourself comfortable. You've got 30 minutes. You can use that time as you choose, and at the end of it all, if there's any time left we'll split that amongst the members who are present here today.

Mr. Curt Flanagan: Thank you very much for inviting the Ministry of the Attorney General to present to this Select Committee on Mental Health and Addictions.

Today, as director of mental health within the criminal law division, I'm happy to provide an overview of existing services and supports that the Ministry of the Attorney General provides. I should indicate to you that when I talk about some of the initiatives, these are initiatives from the Ministry of the Attorney General, but also initiatives with co-partners from other ministries, two of which you will hear from today.

I'm going to talk to you about four areas: the mental health directorate; the mental health and addiction courts and court programs; collaboration with ministry and community partners—additional services and specific services; and also education and training.

In order to put it into context, I've provided a bio in relation to me, and I thought it might be a good idea for members of the committee if I could just explain very briefly, from a criminal law point of view, some of the juncture points that we deal with in court.

There are really three areas that come to be with respect to mental disorder and developmentally disabled. There are the alternatives to prosecution, which may be referred to as diversion, which is a protocol within the criminal law division of the Attorney General; there is the verdict of unfit to stand trial; and there is the verdict of not criminally responsible on account of mental disorder.

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The first area that I've mentioned, and that is alternatives to prosecution, is a protocol from the Ministry of the Attorney General that recognizes that mentally disordered or developmentally disabled offenders may warrant special consideration, with an emphasis on restorative and remedial measures as an alternative. Diversion refers to alternatives to prosecution that apply to low-end offences. Key with respect to making a decision on diversion—and I should indicate to you that the decision to divert or to use alternative means of prosecution, i.e., to take it out of formal prosecution, is solely at the discretion of the crown attorney or assistant crown attorney. As I indicated, public protection is paramount. The offences that relate to this protocol are low-end offences.

When you look at unfit to stand trial, that's a verdict of unfit to stand trial that provides a special verdict for an accused person who appears before the court. Let's say, for example, you have an individual in downtown Toronto who is suffering from schizophrenia and is off his medication, he's in a public establishment and he may be breaking glasses, he may be yelling; and as a result of that he may be charged with mischief and damage to property and causing a disturbance. That person would appear before the court in the criminal justice system. One of the issues may be whether or not the person is fit to stand trial. The person is unfit if he's unable, on account of a mental disorder, to understand the nature and object of the proceedings, to understand the consequences of the proceedings, or to communicate with counsel.

Let me tell you that the fitness test in criminal court is a low threshold. It's been referred to as the limited cognitive capacity test. In practice what usually happens,

and there are derivatives, is that a psychiatrist—because it has to be a medical practitioner under the Criminal Code, which would include a psychiatrist, unless they are designated by the different provinces, which is new legislation that I can get into later if you like. It's an examination by the psychiatrist, and it usually takes between 15 minutes and half an hour. This is not an elaborate examination to determine fitness.

If the person is unfit as a result of that examination, what happens? What happens is the court will then decide whether or not a treatment order is applicable. By that I mean the court will decide, based on psychiatric evidence, whether this person can go to a hospital, can be treated, can be made fit within a 60-day period, which is the time period in the Criminal Code, on consent of the hospital. So what happens in practice is you have a fitness hearing, you have a psychiatrist testify, then after the finding of unfit, you get into the treatment order proceeding and then the court may order a treatment order.

Let's suppose that a treatment order is not appropriate because the prognosis of becoming fit within a 60-day period doesn't exist. Then what happens is really two things. The court can give an initial disposition, in which case the person will then be referred to the Ontario Review Board and receive a hearing within a 90-day period. If the court refuses to give a disposition—and I can tell you, on occasion they might, because the review board is an experienced panel of individuals who have the background of hospital reports—then what happens is the person will get a hearing before the review board within a 45-day period because they didn't have the initial one.

Finally, the last juncture—I said there were three. Alternatives to prosecution was the first one, unfit is the second one, and then there's what has been commonly referred to as NCR, which is not criminally responsible. Of course, that is a specialized verdict under section 16 of the Criminal Code. If you are found not criminally responsible, you are then transferred to the jurisdiction of the Ontario Review Board. You'll receive a hearing within 45 or 90 days and an annual hearing each year after that to determine whether or not you present a significant risk to the safety of the public. If I'm at a hearing at the Ontario Review Board—and I can tell you the Ontario Review Board consists of five persons: a chair, a psychiatrist, maybe another psychiatrist or psychologist, a layperson, and a legal member—evidence will be presented by the hospital and may be presented by parties. At the end of the hearing, there has to be a determination whether the person presents a significant risk. If they do, they will stay under the review board system and a particular disposition is fashioned, depending on the risk level. If they don't, they are absolutely discharged and they leave the system.

Those, in effect, are the three juncture points in relation to mental health.

I said I'd talk about the mental health directorate. The mental health directorate is a new initiative by the

Ministry of the Attorney General in October 2008. I'm proud to say I am the director of the mental health directorate. Our goal is really three goals: to enhance the delivery of service for individuals with mental health issues and the developmentally disabled in the system; to assist in the integration of a seamless transition—and by that I mean to look at every juncture point, from arrest until release into the community, and see if we can improve upon those particular juncture points; and finally, to provide informed assistance to and collaborate with other justice partners. It's clear that collaboration with other justice partners is a very important aspect when dealing with individuals with mental health issues before the court.

The mental health directorate has set up a specific committee which is made up of specialized crown attorneys. These are crown attorneys across the province. There are six judicial regions. For example, in the west region, we will have two representatives, two crowns from that region, so there are 12 crowns on this committee. In addition to that, there are other individuals with special expertise. They may have expertise in the review board, they may have expertise in youth, they may have expertise in policy, and they may have expertise in various other things related to mental health. So it's a very functional and practical committee and I'm actually quite excited about it. That committee has formed working groups, and one of the advantages of that committee is, because of the representatives in the province, they form working groups to deal with practical challenges in each jurisdiction and also to bring to the table, if you like, things that are going on across the province. So that is the first area.

The second area is the mental health and addiction court and court programs. In relation to that, I can indicate—I told you a little bit about alternatives to prosecution. I just want to be very clear that when a crown attorney or assistant crown attorney is looking at alternatives to prosecution, they are really looking at—the present protocol calls for three classifications of offences: class 1, class 2 and class 3. Class 3 contains offences such as murder, firearms and sexual assault. These are prohibited and not allowed to be diverted from the justice system. Class 1 is presumptively eligible, i.e., joyriding, shoplifting, mischief. These are presumptively eligible to be diverted from the criminal justice system. And then there's a larger category of a number of other offences that is in the discretionary category. Crowns will look at the circumstances of the offence, the circumstances of the offender, and decide whether or not they will consent to a particular diversion of the individual, keeping in mind—I repeat—risk to the community, which is paramount.

When I told you about court programs, this is where we share an initiative in relation to my partner ministries; that is, there are what is referred to as mental health court workers. Mental health court workers are present in the court. They are invaluable. They are a tremendous asset. Why is that? Why would you think that they might be a

tremendous asset to us, for example, as prosecutors? Well, if you take into consideration that most courts are very busy, that there is a number of cases, we welcome individuals who specialize, individuals who link to particular services, individuals who have the ability to work up a background in relation to the offender so that I, as a crown, can make an informed decision in relation to risk and as to what is the best program, for example, to use as an alternative to prosecution. I can't say enough about mental health court workers. They liaise with a number of individuals and, quite succinctly, are worth their weight in gold.

You also have mental health court programs and mental health courts. Let me tell you that, first of all, when I refer to a mental health court, that is a court that is sitting either on a full-time basis or a regularly scheduled part-time basis for the exclusive purpose of dealing with disposition of cases involving mentally disordered or developmentally disabled offenders. So that is a court that sits for the exclusive purpose of that population, if you like. That court has a number of persons attached to it. The more persons attached, the more specialized the persons attached, the better and seamless the service is in relation to that particular court. They may deal with not-criminally-responsible issues, fitness issues, disposition hearing, diversion issues or various other things affecting the person before the court.

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The largest one is right here in Toronto, and that is 102 court, which was established in 1998. It is the largest mental health court in Canada, and I can tell you that the number of cases that go through that court in an average year lately is approximately 2,000 to 2,500. That is a very busy court. As a result of that, that court has extensive resources, from dedicated judges, dedicated crown, dedicated duty counsel, dedicated bail workers, dedicated mental health workers, two court clerks and various other individuals who specialize in that particular program.

In addition to Toronto, there is a mental health court in Ottawa, which was set up in 2007; there was one in Peel, in 2002; there was one in London, in June 2007. There was one in Walkerton, and I say Walkerton because—don't get the impression that because you are a large jurisdiction that will necessarily give you a mental health court. Walkerton is a smaller jurisdiction, and they fashioned it—they may not sit as often; they sit maybe once every two weeks—to address their particular jurisdiction. Kitchener-Waterloo is another one, and Windsor is another one.

In addition to these mental health courts across the province—and we're quite proud of them. I should say, and I indicated at the outset, that I share the initiatives with partner ministries, the Ministry of Health obviously being one of the major players in relation to that.

In addition to the dedicated mental health courts, there are mental health court programs. What I mean by that is that if you don't have a dedicated mental health court, you might have a program. Let's take an example: Before I was the director—I'm seconded as the director—I was a

crown attorney in Brockville. What we do in Brockville is, we have a psychiatrist come to our remand court, which is once a week, every Friday. So we attach a psychiatrist, which is a mental health program. We also have a mental health worker in the court.

These various programs will vary. Barrie, for example, has two psychiatric nurses attached to the court. An innovative program, and I would invite you to see this, is in Ottawa, because, in addition to the mental health court, what Ottawa has is a mental health clinic, and there is a psychiatrist right in the courthouse. That psychiatrist sits there once a week, will diagnose individuals and send them on for treatment. That ensures, in my respectful view, the person goes for treatment. It's a monitoring system so that the person makes sure that they attend for treatment, and it tends to catch and identify the large population that might be missed had it not been right in the courthouse.

Then we deal with court-ordered assessments. Court-ordered assessments are very important. Why is that? Court-ordered assessments are important because they tend to go to risk as well as fitness and NCR. When you're looking at court-ordered fitness assessments, what are the innovations? Mental health court programs are doing them, like Brockville, for example, or Sudbury, bringing a psychiatrist to the court. There are also on-site assessment clinics at specific correctional institutions. Why is that important? That's important because if I'm in court, I don't have to necessarily find a hospital bed or get a hospital bed for this individual if the person is in custody in a correctional facility and they have a fitness clinic. So that is a very good initiative, obviously in partnership with Corrections and Health.

Then there's also hospital-based assessment, which is going to the hospital to retain a bed. There was an initiative between a number of partners—Health, ourselves and other partners—where there is an Ontario bed registry. If I'm looking for a bed and there's not a bed, for example, at CAMH in Toronto, there may be a bed opened in Brockville Mental Health Centre or in Ottawa Mental Health Centre. So that is a very useful tool in that regard.

Then we move to the youth. There have been a number of initiatives in relation to youth. Both London and Ottawa presently have a mental health court. What that is, is that their adult mental health court is now accommodating mental health court for youth. They are dealing, however, with transitional-age youth, and that is 16- and 17-year-olds who go to court. London is very innovative. Again, if there are site visits, I would invite you to go to London's youth court. They actually are having a conference on Friday—I'm not suggesting you go Friday. But in any event, they have specialized persons at the court. They have clinicians, and they take a long time with the youth. They'll have a clinician assess. They'll have case conferences. They may bring in the school board to address it. These are youths who are very troubled and have particular mental health issues that are complex and significant, so that's a very good initiative in London, and as I indicated, Ottawa also has it.

Then we move to the addictions. In the province of Ontario, there are presently two drug treatment courts formally funded by the federal justice department. They are in the Toronto area and also in the Ottawa area. In relation to that, they have a whole program that brings people to stop the revolving door, to address addictions, to make sure that the person doesn't come back into court and to get them hooked up to appropriate services. Again, the appropriate services brought to the court and linked by a network are extremely important because you specifically have to address the individual.

There is also an innovative initiative in Durham, for example. They don't have a federally funded court, but they do have a drug court. Durham's drug treatment and community restoration court has two components. It's unique because it addresses the adults in relation to addictions, but it also addresses the youth. Although an adult tends not to be able to get into the drug court if he has a problem with cannabis, the youth in that jurisdiction do get into that restoration court with a cannabis problem. I should indicate as I speak a brand-new initiative in Hamilton called SURCH, Substance Use Related to Crime in Hamilton. That is a similar way to fashion it.

The aboriginals, with respect to the addiction support programs for aboriginals, also supply an aboriginal court worker program. These are invaluable persons. Why are they invaluable? Because they know their community. They know how to link the persons up to particular programs that I may not have any knowledge of as a crown, that the judge may not have any knowledge of it. But these particular court workers, aboriginal court workers, are extremely important. And I hate to keep coming back to it, but it's the specialized service that is really advantageous in the court. Again, we have what are referred to as Gladue case workers providing Gladue reports, which are like pre-sentence reports, but frankly focus on, specifically, background in relation to aboriginal offenders. It's a very helpful program.

In addition to that, there are the aboriginal community justice programs. The Ministry of the Attorney General, in partnership with the Department of Justice, funds 11 aboriginal community justice programs. The range of services is for pre- and post-charge diversion, Gladue report service, pre-sentences and various other things assisting the court. For example, the Rama First Nation has direct access to a range of mental health services delivered by professional staff using a blend of western and traditional approaches, where both a psychologist and a community elder respond to the community's mental health needs. An aboriginal community justice program in Mohawk Council, for example, has direct access to fetal alcohol spectrum disorder assessments and diagnoses within their territory. Why are they valuable? Again, because they specialize.

The third component that I said was important in relation to the mental health directorate was collaboration with ministry and community partners. No time is better than the present to continue our collaboration in relation

to various ministry partners to look at persons with mental health and addiction issues. In this regard, one of the community partners that I find quite valuable that you may have heard about—I'm not sure whether you did or not—is the Human Services and Justice Coordinating Committee. To explain it very briefly to you, the Human Services and Justice Coordinating Committee is a committee that sits in most, if not every, jurisdiction across the province, made up of various players including crown, defence, probation, medical services and various other mental health workers to look at challenges and to look at practical solutions in relation to how to deal with the mentally disordered as they pass through the court. It's very valuable. What they do is, in relation to these specific jurisdictional committees, they lump them into regional committees, and then there is a provincial committee. So you can see it's a very effective structure that alert—there's a lot of talking. To put it quite bluntly, it's fine to know what the other person is doing, but you have to share information and you have to talk. If you do that, you're able to recognize and come up with innovative solutions, both from a practical point of view and ones that may not take up a lot of time or money.

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In relation to the Attorney General: The Attorney General, the Honourable Chris Bentley, has established a round table to address existing challenges in mental health and addictions within the criminal justice system. The round table is made up of multidisciplinary individuals with expertise in mental health and addictions. It is a wide range of individuals. It includes seven human services regional chairs, forensic psychologists, forensic psychiatrists, police, defence lawyers, members of the schizophrenia society and various other members who are very informative in looking at challenges. That is an excellent committee.

Then we have interministerial committees. You may hear from my friends from Health that there is a 10-year strategy for the mental health and addictions committee. But in addition to that, I think it's important, for the Ministry of the Attorney General and clearly I as director, that I may sit with other individuals from Health or children's services to look at particular practical issues.

I didn't want to leave out the Ministry of Children and Youth Services, because one thing that they provide—albeit there's a limited number—are mental health youth workers. Think of that as the adult mental health worker, but in youth court. Those, again, are invaluable. There are a certain number of them, they're not in every jurisdiction, but the information they provide goes a long way to help individuals, particularly youth, before the court.

Often, as a prosecutor, you might have a parent come to you and say, "I'm dealing with my 16-year-old or my 17-year-old and I can't get him into any service. Thank God"—and this is a sad comment, in my respectful view—"he's charged with a criminal offence, because maybe now I can direct him. Maybe now he'll get the services that he needs." I say that for two reasons: One,

that shows how effective these systems are that are being put in place across the province; and two, there is a certain amount of comfort zone in relation to individuals—albeit, it may be in the wrong place—a comfort zone to look after the youth.

I don't want to give short shrift to other divisions in the Ministry of the Attorney General. If I'm mindful of the time, I think I have three minutes.

Let me tell you that the Office of the Public Guardian and Trustee delivers a unique and diverse range of services that safeguard the legal, personal and financial interests of mentally incapable persons: for example, in the past year, 5,282 decisions for 4,011 individuals who were incapable of making these decisions. They produce valuable work. Their work is continuing and they are an extensive service to those individuals who are mentally incapable and who, for example, need lawyers, which this particular office is able to facilitate.

Lastly, there is victim services. Victim services also has a number of initiatives within the Ministry of the Attorney General. Victim services, for example, has specialized staff in their particular secretariat—specialized in the sense that they know to refer individuals with mental health challenges to the particular services that they need. In addition to that, the secretariat has funded 10 grants relating to mental health or addictions, including, for example, Bridging the Service Gap for Sexual Assault and Mental Illness Survivors and rural strategies for victims of abuse and mental health and addictions.

I did say lastly, but I will end with education, because education is very important. From the Ministry of the Attorney General, there are a number of education initiatives. We run a specific mental health course every year for one week. That is an all-comprehensive course that brings in experts—psychiatrists, legal experts, members of the board, mental health professionals. We go from A to Z. We don't just look at the Criminal Code, we look at the particular disorders, so I know as a crown counsel: What are the indicia of risk for a person with mood disorder? What are the indicia of risk for a pedophile when I deal with him at the Ontario Review Board?

We also have an introductory course for new crowns that covers the Criminal Code in relation to mental health. I should say that there is an aboriginal justice course, and in addition to that, the office of the public guardian has training, as does Ontario victim services. Finally, the court services division, in relation to their accessibility plan, has specialized training and resources for court staff and justice sector partners who serve persons with mental health and other disabilities. That is an ongoing training process that'll take place within the next year.

Let me end by saying this: There are three things that are very important in relation to criminal court. One is a timely and informed assessment. We, as crown counsel, have to be able to make decisions in relation to risk, as does the court.

Second of all, we need informed protocols and networks to make sure the right persons are in the jurisdictions. I used to think, when I came on this position in late October, that there was one shoe that fits all. I don't think that anymore. I think, depending on the jurisdiction and the size of the jurisdiction, you can implement protocols to make sure that everyone is working together, because with respect to mental health and addictions, it's very important that we share information and everybody works together.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Mr. Flanagan. That was an information-filled half-hour; lots of information there for the committee to digest. Unfortunately we have no time for questions, but I did want to thank you for making full use of your half-hour. You can take a breath now. Thank you very much for attending.

GERSTEIN CENTRE

The Chair (Mr. Kevin Daniel Flynn): Our next speaker now is from the Gerstein Centre, and it's Paul Quinn, executive director, if Mr. Quinn would like to come forward.

Mr. Paul Quinn: I brought some people who have been working with me for the past few years.

The Chair (Mr. Kevin Daniel Flynn): No problem at all. Take a seat.

I just noticed we've got a Flanagan, a Quinn, and a Flynn in the chair. There's going to be a fight here somewhere, right?

Mr. Paul Quinn: Hopefully so.

The Chair (Mr. Kevin Daniel Flynn): If you'd like to introduce yourself and perhaps introduce your colleagues for Hansard, so we can get that on the record, and you have 30 minutes to use any way you see fit. Welcome to the committee.

Mr. Paul Quinn: Hopefully we can have some questions, some interaction. That would be great.

I'm Paul Quinn, executive director of the Gerstein Centre, which has been around since 1990. It's a Ministry of Health-funded program. With me is Susan Davis, who's the coordinator of our mental health and justice program and partnership program; Nicki Casseres, who's the coordinator of our training and education and volunteer program; and last but definitely not least, Michael Creek, who is co-chair of the board of directors. He runs the Voices from the Street program, which is a consumer survivor group that works with people who have experienced poverty and homelessness.

I thought what we'd do is just go through what the Gerstein Centre does for you, and each of us will do a little bit of a piece of that and then talk about some of what we think are important things for the community to look at.

The Gerstein Centre is a non-medical crisis intervention centre in downtown Toronto. We've been operating since February 1990, and we have three primary pieces to the service in our original site, which is on

Charles Street. That is: phone access 24 hours a day, seven days a week for anyone who's experienced a mental health crisis of some kind, including whether they think it might not be a mental health crisis. We get 50 to 70 phone calls per 24 hours.

The second piece of the service is a mobile team that actually will go out on-site to meet the individual wherever they are to try and help resolve the crisis. They're always looking for practical, concrete kinds of solutions to whatever situation they're in in an attempt to make sure the crisis doesn't get worse, or helping them develop the skills so that it doesn't happen again.

We also have a 10-bed house on Charles Street, a large Victorian house that's in the middle of, now, a bunch of condos, but it's sort of just sitting there all by itself. It's been invaluable in allowing people a short stay of three to seven days where they can sort through how they got into the crisis in the first place, what kinds of things they might be able to do to prevent it from happening again, and for the staff to have an opportunity to make the connections for the individual so that they don't get into crisis again and that they have the supports in the community. It could be case management; it could be financial; it could be looking at housing alternatives.

In downtown Toronto, about 30% of the people we see at the Charles Street site are homeless or living in poor housing, hostels or boarding homes. That's one of the critical issues for people: trying to find them decent housing that they can maintain.

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I think I'll get Susan to talk a bit about our new program, the mental health and justice beds on Bloor Street, which she can describe. She's the coordinator of that program and has worked on that for the last two years.

Ms. Susan Davis: First, it's called Gerstein on Bloor, and it actually houses two programs at that one site. One is the female crisis beds which are aimed at women who are experiencing a mental health crisis and are currently homeless. We have five beds on a female-only floor within that house.

We also have the mental health and justice short-term residential crisis beds located at that site. That's for the downtown area; it's part of a larger network of beds. I think there are 34 beds across Toronto, some in Etobicoke, some in North York, Scarborough and then downtown. We have the nine downtown mental health and justice beds located at Gerstein on Bloor.

Those are for individuals who may be dealing with a mental health issue or a mental health crisis and are having current involvement with the criminal justice system. Mr. Flanagan was talking a little bit about the diversion programs through the courts. Many of the folks we would have coming into our site may come through the courts. They may also come from discharge out of a correctional facility. They may be involved with probation, or they may just be in the presence of police.

Again, the beauty of that program is this sort of cross-sector co-operation that's really put in play to try and make sure that when the individuals are coming back to

the community, once they've had the experience in the institutional setting—whether it be a courtroom, a correctional facility or even perhaps a hospital, if fitness is an issue—there are in fact supports in the community for them to actually get the resources they need so as not to end up in crisis or back in the hospital or back in the court system.

Those are the 14 beds that exist over at Gerstein on Bloor. We don't have the other aspects; the crisis team we utilize through the original site. What we do is short-term case management with people, connecting them up to resources so that they are supported as they leave us, hopefully within 30 days, although we're finding a really hard time getting people connected up within 30 days because community resources are limited and 30 days is a quick turnaround to try and get somebody housed.

Mr. Paul Quinn: Nicki will speak on the—

Ms. Nicki Casseres: I got lit up, so it's my turn.

The other component, because we are an organization that promotes early intervention, is a lot of outreach. We also do a lot of education in crisis intervention, suicide prevention and mental health awareness. Part of what is important to us is that people who are working with people with mental health issues are aware of our service, because the earlier we can get to that person who is in crisis, the less intrusive the intervention is and the more options that person is going to have.

We do training with the TTC, with the police, with community-based organizations, with hospitals. We've been across the province, across the city to Brampton, working with people with autism, children who have mental health issues, teaching people about not only Gerstein Centre but other crisis services within their community and that it's important that people access those services early on in their crisis, because we feel that is key to our success. People phone us up early on and we can do a lot over the phone with that person.

The other component that we have which is very important is two training positions. We have one training position for someone who is new to this country and has worked in mental health in their country of origin but hasn't been able to gain employment here because we don't recognize their work experience or their educational background. We provide a full salary; we train them, get them familiar with our system and how it works. Most people who have gone through that program are now working in mental health, and some of them were physicians or doctors who are now physicians or doctors doing the things that they were originally doing in their country of origin.

The other training that we have is for someone who has a mental health issue and because of that mental health issue has not been able to obtain employment because of barriers, because of the nature of having a mental health issue. Maybe they have part of a degree or periods of time of unemployment, but they show potential to be able to work in the field of mental health.

Again, it's a year-long training; it's a full salary with holiday and benefits. Everyone who has gone through

that program and has completed that program is now working in the field of mental health. We just hired someone recently. We had over 200 applications; we interviewed 20 people for the one position. Most people who come there come with a lot of hope and dreams that they will be able to then begin to work. I think one of the things we're always looking for is to create opportunities for more training for people who have mental health issues, because one of the things that happens is that you get this illness and people tell you that you can't dream anymore, that you can't have a career, that you're stuck with this illness, and so we always look for those opportunities.

Michael's going to talk about one of those programs that we have worked on that has created opportunities for people, Voices from the Street. The idea of that program is that we get people who have experienced homelessness or mental health issues and we train them to go back to their communities and become leaders, and to come and speak and advocate on behalf of their own selves to change the system. Some of them will do it while coming to speak here today, or some of them will go back to their communities and talk to the people in their community, other people who have mental health issues or doctors or professionals, and try to make changes in that system.

I'm going to pass it over to Mike.

The Chair (Mr. Kevin Daniel Flynn): Okay. Before you start, if you could just introduce yourself again. I'm not sure if they caught it the first time on Hansard.

Mr. Michael Creek: Sure. My name is Michael Creek and I'm the coordinator of Voices from the Street. I'm also a graduate of Voices from the Street, and that is one of the reasons why I'm here today to speak to you.

In 2005, the Gerstein Centre, in partnership with the Ontario Council of Alternative Businesses and the Parkdale Activity-Recreation Centre, developed a pilot project funded by the city of Toronto to train 12 individuals, who Nicki has mentioned, who are either homeless or have experienced mental illness. The project is built on the premise that people who have been homeless or have gone through mental illness are vital members of the community and deserve the opportunity and chances to make changes and to change the public perceptions and attitudes towards those who experience mental illness. Usually I don't speak a lot off the cuff, but I'm going to speak off the cuff and not from written notes today because it's an area that's very near and dear to my heart.

In 2007, I was at the very bottom of the pit, living in poverty and having 30 years of being a psychiatric consumer/survivor, and I came across a poster that talked about Voices from the Street. Often we see or hear about opportunities or chances for people to get back into society, to reintegrate ourselves to become productive again. Often these things are just resumé writing and they often are dead ends, so I didn't pay much attention to it, but I ended up applying and I was accepted. From that day, my life has completely changed around. That initiative that came about for giving people that opportunity has completely changed my life. Two years ago, as I said,

I was living in poverty. Last weekend I was out looking at maybe purchasing a condominium. This is the type of programming that is so innovative that I'd like every person to have that opportunity to be where I am today. Those opportunities and chances for people are too far between—people just don't get those opportunities.

One of the things that is important also is that other people I have taken the course with and other people with whom I've been there through their training process—there's a tremendous change in people who have suffered very serious mental illnesses. All of a sudden people are coming in after a couple of weeks and they look healthier; they're taking less medication. People are making less visits to see their psychiatrist, less hospital visits. So Voices from the Street has made a tremendous difference. We have many people who have gone on now either to part-time employment, full-time employment, or on to volunteering to start rebuilding their lives.

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So when we think about how \$1 can really make a difference for people when it's outside of the sort of medical block—we often think that all that people who are psychiatric consumers/survivors need is a pill or maybe some counselling. It's much more than that. It's these types of opportunities and chances that really make changes in people's lives. This hasn't just happened to me; the exciting part now is that I get to see this opportunity and chances for many other people. I just can't tell you how much joy that gives me. It should give all of us joy that people are allowed an opportunity, a chance to rebuild and change their lives.

The Chair (Mr. Kevin Daniel Flynn): Thank you.

Mr. Paul Quinn: In thinking about coming here today, we looked at the services we provide in helping people getting through a crisis. We looked at some of the things that we see as key as a community organization that works with hospitals, hostels, detox centres, ambulance, police—sort of everybody in the system, we get referrals from or we give referrals to. So we see a lot of different things that come through it.

For us in downtown Toronto, one of the things that we really think needs to be focused on is the determinants of health and wellness. I'll just read off what we've done, because several people put the work in on this: Investment in the wider social and economic base will contribute to lifelong health and wellness. For example, an increase in income support programs, investment in safe and affordable housing, primary health care, education supports and job creation are critical in an economically sustainable health system and to individual mental health recovery.

I think the other thing is access to community-based services. Smaller services sometimes can be more accessible and react quicker to changes in the client group than larger ones. Larger ones are good in terms of some of the one-stop shopping kind of look at things where you can get a lot of services in one place. But sometimes specific kinds of services that are geared to one particular kind of population are really good. I think consumer/survivor initiatives are critical to support places like A-Way, Fresh

Start and OCAB, where people who have been through the system themselves, who experienced that themselves, are actually running programs, operating them and providing help and support and a community for people who have been diagnosed with a mental illness.

Ms. Susan Davis: I wonder if I could just add to the point around access to community-based services. We've heard many reports that have said that we need to improve services offered in the community. Mr. Flanagan was talking about a family coming to court and saying, "Thank goodness we're here, because now maybe our son will get some help." I think we really need to consider access points for individuals into the mental health system. They need to be multiple and they need to be accessible. Hospitals are an access point, and unfortunately our criminal justice system is an access point at this stage in terms of how we're set up, but greater resources put into the community with accessible resources could really make a difference for people in their lives in terms of being able to access services.

Another plug in terms of those services being coordinated across sectors and how important that is, because then people can access at one point and recognize that they may have needs in other areas and still be able to flow through the system and get those needs met from that single access point—so instead of thinking about a single access point as a well-coordinated system, thinking about multiple access points that then coordinate together as being a really effective way to improve accessibility across all communities, whether in a large centre like Toronto or other centres which are smaller than that.

Mr. Paul Quinn: I think you can see that in the mental health and justice programs that got funded. A large number of different organizations are working together: CMHA, COTA, Reconnect, Gerstein Centre, CRCT. A number of programs that are funded by the Ministry of Health under the mental health and justice umbrella work together to make sure that an individual can get service all the way through, that once they get out of jail, they have a place to stay; that's through Safe Beds. Once they get through Safe Beds we'll find housing, and there were I think about 500 units that were funded across the city. Those units filled up in about six months. So there's a huge need for housing, decent, affordable housing for people.

That was for a very specific population, not for the whole group of people with mental health issues, but for the people who were coming out of jails or in contact with the justice system; so 500 units filled up quickly. So that needs to happen.

Working on access issues within that network was really valuable to all of us, I think. We got to look at things through a different lens and work together, in spite of some slight differences in philosophy, to make sure that the client got what they needed.

Ms. Susan Davis: And then the other thing that came out of that—

The Chair (Mr. Kevin Daniel Flynn): Susan, could we get your last name again? I'm not sure we got it the first time.

Ms. Susan Davis: Davis.

The Chair (Mr. Kevin Daniel Flynn): Thank you.

Ms. Susan Davis: The other thing that came out of that, as well, is sort of the recognition of the gaps that emerge. They're cross-sector. Whether you're in the criminal justice system, whether you're dealing with youth, whether you're in the developmental sector or in mental health, a lot of these issues that, through good service coordination, emerge are very common, housing obviously being one of the issues. One of the other issues that's emerged very strongly is access to primary health care, psychiatric assessment and ongoing support in the community, not necessarily through an institutional setting. But both are needed. I think you've probably already heard from a number of sources that that's a major issue for us here in Toronto and, I think, across Ontario.

One of the other things, though, that I think is really important and that hadn't occurred in that particular instance was the opportunity to hear from consumer/survivors, individuals who have lived experience of our systems and as well, lived experiences of mental health issues. Being able to hear their voices in our efforts to doing this service coordination is a really important piece, and I think hearing from Mike today really spoke to that.

Mr. Paul Quinn: We thought we'd leave you some time for questions. We have a couple of minutes.

The Chair (Mr. Kevin Daniel Flynn): Wonderful. That's good; you've left about 10 minutes. Sylvia, do you want to take three minutes, and then Michael?

Ms. Sylvia Jones: First of all, thank you for your presentation and for giving us some time to ask these questions.

Paul, you mentioned that in your Charles Street site, the stays are three to seven days?

Mr. Paul Quinn: Yes.

Ms. Sylvia Jones: That seems incredibly quick. Tell me how you can do that.

Mr. Paul Quinn: It is incredibly quick, depending on the issues that the person has when they come in. If housing is the primary issue, then for sure that's way too short. We do have a partnership with the Salvation Army Maxwell Meighen Centre, funded through the Ministry of Health, for their primary support unit for men, so there's a 30-day stay there. They have 10 beds where people can stay for an initial 30 days after they've stayed with us, in order to make the housing connection.

Often the three to seven days is enough time to get over an immediate crisis and make some plans towards what's going to happen after that. The follow-up on that needs to be done by case management, needs to be done by a number of other services which we don't have connected with us necessarily, but which we'll try to make a connection with in the community. Often a one-day stay is enough for some people. If the situation is really bad, if they can get away from it for a night and then sort through what the next step might be, then they can get through it. Our average length of stay is about four and a half days.

Ms. Sylvia Jones: Okay, thank you. The other question that I had related to funding. You mentioned that it was the Ministry of Health that funded you?

Mr. Paul Quinn: Yes.

Ms. Sylvia Jones: Has that now gone through the LHINS? Are you dealing with the LHINS?

Mr. Paul Quinn: Yes, we're now with the LHINS.

Ms. Sylvia Jones: Okay. Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Sylvia. Michael, any questions?

Mr. Michael Prue: Sure, a couple. You mentioned, and I think with some sadness, that one of the major ways that people get access is through the courts. How many would be able to just walk in off the street and how many are referred by the courts?

Ms. Susan Davis: In terms of the Charles Street site, it's all self-referral. I think that's a really important factor to the service, that people can self-refer. It breaks down the barriers to being able to reach out for service. That's what Nicki was talking about: early intervention and being able to respond early on, because people have a sense that things are going askew earlier than maybe when they're going to take the step of going to a hospital or taking something else. If they can easily access support, then that's going to be really important for them.

The mental health and justice beds specifically are all accessed through criminal justice priority referral sources. In some ways it's a problem, because there are lots of people who do fit the criteria who can't access the service because they're not coming through that resource, but I think the idea being that we knew that the demand for the program was going to be huge, and it was. The minute we opened, we were full—not ongoing, but the beds filled quickly. So we really wanted people were currently involved.

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There are other aspects to the network, including crisis prevention, where people can access it if they are not currently involved but at risk for becoming involved. That's largely delivered through a case management model, except for downtown, where there's a drop-in model.

Mr. Michael Prue: About a year ago, I had maybe a dozen or 15 people come to my constituency office, parents of teenagers, 17 or 18 years old, who were contemplating suicide and then doing a number of really bad things to themselves. There was really nowhere for them to go. Some of them had to be sent to the east coast; some were sent to the United States. The parents told me that they sometimes wished that their children had been involved with the law, because they could have easily been dealt with, but they weren't being dealt with. Is that same circumstance still existing?

Ms. Susan Davis: Despite the fact that there are excellent resources in our courtrooms—and I think Mr. Flanagan outlined some really great resources that you heard about—by no means are they all-comprehensive and perfect. There are a lot of gaps that still exist. We had a defence lawyer speaking at our last human services

and justice coordinating conference, and he talked about that being a misconception, that going into the court system would then somehow get you the access you need. He talked a lot about working with families who were under that impression and then became very disappointed when that wasn't what happened. The reason I speak about it with disappointment is, it is certainly not an access point that is positive for people, whether or not it's effective, which, many times, it isn't. But on top of that, there is the added stigma, and even just a criminal record that can come with that, when there should have been an access point that didn't involve any of that.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Susan. We're going to move on to the government now. Any questions, Maria?

Mrs. Maria Van Bommel: I guess we'll start by saying that very often we hear things about economy of scale, yet you talk about the fact that because you're a smaller service, you're able to make adjustments quickly. I'm just trying to understand how. I know that in the world now, where we all try to be big and everybody seems to think that that's the way to go, and there are economies of scale and efficiencies, you're saying that because you're smaller, you can make adjustments quicker.

Mr. Paul Quinn: I think that when you get to something that's larger, you have a bigger bureaucracy, you have more rules around access, and you have more things going on that make it difficult to actually just listen to the person, find out what they want and then move them to that. You have to jump through hoops to get there. A smaller organization is able to see the person and make a decision. Look at places, drop-in centres like PARC or Sound Times. They're smaller organizations, and people come in the front door and they can identify really quickly what they might need. The staff have the autonomy to be able to make those decisions around where they need to get them. They don't have to get approval from a supervisor or run things through some kind of a bureaucratic paper trail. They can—

Mrs. Maria Van Bommel: So the decision-making is actually right at the point of contact?

Mr. Paul Quinn: Yes.

Ms. Susan Davis: That's right.

Mr. Paul Quinn: That's where it's critical, especially if it happens to be—I think if it's for a specific population, like for an aboriginal population or for other areas—current disorders—those kinds of things where if you really need to make decisions fairly quickly when you get an individual, it's good to have it small enough that it can react quickly.

Mrs. Maria Van Bommel: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for attending today. Thank you very much for your presentation.

Ms. Susan Davis: We brought a package that we'll leave with you so that you can have some of that information.

The Chair (Mr. Kevin Daniel Flynn): Thank you.

Mr. Paul Quinn: You're all invited to come visit the Gerstein Centre any time you want a tour.

The Chair (Mr. Kevin Daniel Flynn): Okay, we might just take you up on that.

MINISTRY OF HEALTH AND LONG-TERM CARE

The Chair (Mr. Kevin Daniel Flynn): Our next presenter today, from the Ministry of Health and Long-Term Care, is Ron Sapsford, deputy minister. If you'd like to come forward, Mr. Sapsford. You've got 30 minutes. Thank you for attending today. If you have any colleagues with you, if you would introduce them in your opening remarks for Hansard, that would be appreciated. The floor is yours.

Mr. Ron Sapsford: Thank you, Mr. Chair and members of the committee. On my right is Susan Paetkau and on my left is Anne Bowlby, both members of the ministry staff who are with me here today.

Thank you for the invitation. I won't take too much of your time talking. I've assumed this may be the first time the ministry is in front of you, so what we've tried to do in preparing for today's presentation is to give you a high-level overview from our perspective of the mental health system—some of the services. In the binders that we've left for the committee, we've tried to give you a bird's-eye view of some of the components and a little more detailed information on different aspects of the health care system. The information you have, of course, is backed up in the ministry with large amounts of detailed information. As you go through your exploration of the topic, if there is additional information, numeric or otherwise, that you might require for your deliberations, the ministry certainly stands ready to help you with that and to provide additional information.

Thank you for this opportunity to outline the province's mental health and addictions system. The binder that you've got will provide information on mental health and addictions reflecting the committee's terms of reference.

I'd like to start by briefly outlining the health system's structure and the roles and responsibilities of the various players in the context of the mental health and addictions system.

The Ministry of Health and Long-Term Care is responsible for the development and coordination of policy and program standards relating to the province's health system. The province's 14 local health integration networks are responsible for planning, funding and integrating local health service providers. The LHINs establish accountability agreements with community mental health and addictions agencies and are responsible for allocating funding to these organizations. The boards of directors of the individual provider organizations—the hospitals, community mental health and addictions agencies—are responsible for the leadership and direction of their own organizations in the provision of service.

We all recognize that mental health and addictions issues have a huge impact on society. One in five Ontarians will experience a mental illness in their lifetime.

About 10% of people in Ontario are dependent on substances, including alcohol. About 250,000 people have moderate to severe gambling problems in this province. One in seven hospital days involves people with a diagnosis of mental illness. The economic cost of mental health and addictions for Ontario is estimated to be in the area of \$34 billion per year. About half of those with gambling concerns also have issues with substance abuse or psychological functioning.

Mental health and addictions are a serious issue, and there are challenges in meeting the demand and ensuring coordinated care for people with addictions and mental illness, particularly for those with co-occurring mental health and substance abuse disorders at the same time.

In 2008, the Ministry of Health and Long-Term Care spent \$2.6 billion on services for people with mental health and addiction problems. This would include community, hospital and physician services, as well as the cost of drugs. This number is broken down by category in the information provided to you to give you a sense of the distribution of expenditures across the full range of mental health and addiction services. But to give you an idea of what some of the funding went for, over 71,000 clients received substance abuse services, almost 5,700 clients received problem gambling service treatment, and over 642,000 clients used community mental health services in the province.

The community mental health budget rose by over \$200 million, or 54%, between 2004-05 and 2008-09. The ministry has provided \$29.1 million for stabilization and improvements to the community mental health system, a 7% increase in base funding since 2004-05.

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Currently, the government provides \$679 million to community mental health agencies for a wide variety of services and supportive services, including:

- over 300 community mental health programs. These services allow people to live full lives in the community with the supports that they need to be independent.

- assertive community treatment teams. These are 79 self-contained, multidisciplinary teams providing necessary services to people with serious mental illnesses on an ongoing basis. This has meant a cost avoidance equivalent of about \$120 million per year, keeping people with serious mental illnesses out of hospitals.

- crisis intervention, which is offered by telephone or mobile team;

- intensive case management;
- early intervention in psychosis;
- vocational programs;
- consumer/survivor initiatives; and
- supportive housing.

This represents the full range of services provided in community mental health treatment.

Most people with mental illness or addictions use their family doctor as a primary service provider. The ministry has added mental health counsellors into multidisciplinary teams like family health teams and nurse practitioner-led clinics. Family doctors also provide mental

health care and referral as needed. In fact, the recent agreement with the Ontario Medical Association provides enhanced payments to physicians for meeting minimum targets across a core set of office-based services which include mental health services. And family physicians groups that demonstrate a focus on priorities, which include mental health, will receive salary support for an additional 500 registered nurses. Of that allocation, 150 are already in place.

In addition to the provision of community and primary care services, people with symptoms of illnesses such as bipolar disorder or schizophrenia usually turn to hospitals for care.

In terms of infrastructure to support the whole mental health system, there have been a number of innovations in the past several years. The ministry funds one such agency, ConnexOntario. In the early 1990s, the ministry began with a Drug and Alcohol Registry of Treatment, which is referred to as DART. This registry was started so that people with problematic substance use issues could find services in the province.

In the late 1990s, we began funding the Ontario problem gambling helpline in recognition that people with gambling problems need a place for information and referral. In 2006, as an extension, we began funding Mental Health Service Information Ontario, which provides referral information to citizens on request.

For addictions specifically, the ministry currently allocates about \$123 million for 150 substance abuse treatment programs across the province. Treatment programs in this area include withdrawal management and community counselling, as well as residential treatment and support. Also, an additional \$10 million will be allocated to substance abuse programs starting in 2009-10.

In the area of drug and alcohol treatment, the ministry also funds the information system, DATIS, which is a client utilization system that is used for planning purposes. When the province began funding programs for problem gamblers, problem gambling service utilization was included as part of this information system.

In the area of problem gambling, the following resources are also available: 49 community treatment programs across the province, as well as residential treatment services in four communities; extensive training for counsellors and allied professionals; a helpline; and funding of a research centre into problem gambling.

As you're probably aware, problem gambling funding is through gross slot machine revenues at charity casino and racetrack operations. The amount of funding available is based on a 2% levy, or a 2% proportion, of those revenues.

The ministry has also recently increased the capacity of youth residential addictions treatment services through the addition of 20 additional beds, 15 of them English and five French, in Ottawa. We've also started to fund additional beds—16 youth beds—in the Waterloo Wellington LHIN in addition to an existing program. These investments respond to the need for additional

capacity for youth who require residential addictions treatment and reduce the need for out-of-country referral to US services.

Finally, I'd like to talk about the minister's decision to form an advisory group for mental health and addictions. This advisory group was started in the past year and is in the process of assisting the ministry in developing a 10-year strategy for mental health and addictions services. The strategy will include a review of specialized community and institutional services, the health care system and broader community services as well as mental health issues in the workplace.

The group has met on a number of occasions and has selected five main topics to frame the discussion: the design of the system, healthy communities, consumer partnerships, early identification and early intervention and, finally, building capacity and competencies in the area of mental health human resources.

The minister's advisory group is providing an opportunity to raise the profile of mental health and addiction issues, to identify opportunities to leverage existing resources and to ensure that the concerns and needs of people and families living with mental illness and addiction are addressed. The first interim report is posted on the ministry's website and is available in the binders we have provided for you today.

As part of the development of the strategy, the Ministry of Health and Long-Term Care is working with other provincial ministries to meet the needs of varied client groups. A list of these ministries that we're working with is included in your binder as well. Ministry representatives are meeting in order to determine policy and program direction so that a comprehensive, government-wide response to mental health and addictions issues can be developed co-operatively among ministries.

We all recognize the need to enhance mental health and addiction services to further develop a comprehensive system that puts the person first, is barrier-free and easier to access and navigate.

Once again, I thank the committee for this invitation, for the opportunity to speak to you today. I'd be pleased to answer any of your questions or to receive any comments or suggestions about further information that you might require. Thank you, Chair.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much, Mr. Sapsford. You've left quite a bit of time, about 18 minutes, so we'll take six minutes each, starting with Michael.

Mr. Michael Prue: The first question I happened to ask the last group, but I think this is the more appropriate one: You've written on page 10, "These investments respond to need for additional capacity for youth who require residential addictions treatment and reduce the need for out-of-country prior approval for these services." There were a lot of children going out of country and out of province; some went to the east coast. How many are out-of-country today?

Mr. Ron Sapsford: How many are out-of-country today?

Mr. Michael Prue: Yes. How many are we funding?

Mr. Ron Sapsford: I could find that out for you, specifically.

Mr. Michael Prue: Are we still funding out of country or do we have enough here now?

Mr. Ron Sapsford: No. There are still patients who receive care out of country—yes.

Mr. Michael Prue: How many more beds, then, do we need to make sure that all of our children are looked after in their country, in their province, where they live?

Mr. Ron Sapsford: People make choices about going out of country for specific services. We're endeavouring to supplement the capacity for the kind of care that is included as part of our treatment regime in Ontario. There have been some gaps in that capacity, as we indicated. The additional resources have improved the situation overall.

Mr. Michael Prue: What is the waiting time? Part of the complaints I was getting was that the waiting time might be 12, 15, 16 weeks. Parents were apoplectic that their child might be dead by that point and they ran off to the States or wherever. What is the waiting time today?

Mr. Ron Sapsford: I can get that information for you and return it to the committee.

Mr. Michael Prue: Okay. The second set of questions I have relates to supportive housing. You've included that on page 6 as one of the things that needs to be done: "housing and supports for people with serious mental illness and addiction problems."

A number of years ago, there was a need identified, I believe, for some 6,000 such units in Ontario; there may be more identified today. How many have been built?

Mr. Ron Sapsford: Since that date? We'll provide the information. I can't answer you.

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Mr. Michael Prue: How many people are living in supportive housing today?

Mr. Ron Sapsford: You can answer that.

The Chair (Mr. Kevin Daniel Flynn): Could you identify yourself?

Ms. Anne Bowlby: I'm Anne Bowlby.

The Chair (Mr. Kevin Daniel Flynn): Thank you.

Ms. Anne Bowlby: There is a fact sheet at the back on supportive housing, and I believe—thank you. I don't have my glasses on. I'll have to hold this out a little bit.

Mr. Michael Prue: You could borrow mine, if you need them.

Ms. Anne Bowlby: Actually, they're in my purse.

We do have 8,500 units of supportive housing for people with serious mental illness across the province. That's a mix of dedicated as well as the rent supplement.

What we've been doing in the last few years, actually—I can't even tell you how many years it is—instead of building, we've been offering rent supplements. It allows people to live in a number of different community places. The mental health agencies are the ones that provide the supports, whether it's case management, connection with an ACT team, or whatever the supports are that the person needs in order to live independently,

Mr. Michael Prue: Okay. So the person would live in an apartment, in somebody's house somewhere, and the team would come to them.

Ms. Anne Bowlby: Yes.

Mr. Michael Prue: Is that as efficient as having a unit of, say, 12 or 15 people living in a building with the support on-site?

Ms. Anne Bowlby: I think that for people with mental health, that's probably the most independent way that we could offer it. I don't know if you're going to be hearing from the Dream Team here, but certainly, they have some pretty strong views on how housing should be offered, and that there should be choices for people.

Mr. Michael Prue: That's fair enough. I listen to them a lot—a great group.

Ms. Anne Bowlby: They are.

Mr. Michael Prue: In terms of the supportive housing, has there been any money identified in this year's budget for the purchase of additional supportive housing? Or are you going to continue to rely on supplement?

Ms. Anne Bowlby: Not for mental health. There is some money identified for supportive housing for people with problematic substance use issues, and hopefully, that will be starting this year.

Mr. Michael Prue: In terms of the services that are given to survivors or people with mental health issues, is it still the goal of the health team to provide job counselling and help people to get a job? It seems to me that once you put a roof over their head and provide an opportunity to get a job, many of the difficulties seem to disappear. We had Mr. Creek give a very moving story earlier today. Is that the experience? And what success have you had with that?

Ms. Anne Bowlby: There are a number of alternative businesses that we have funded, and that's something that we can get you some more information on. There are also vocational counsellors within ACT teams, within a number of the agencies, who help people get regular jobs.

One of the challenges for people with serious mental illness is that they often can't work a 40-hour week. The alternative businesses are a fabulous alternative for them, because they can work the number of hours that they're able to, and continue to collect their disability pensions.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Anne. Thank you, Michael. From the government—Jeff?

Mr. Jeff Leal: I have a question for the deputy minister. If I could just go back, Mr. Sapsford, to your presentation, on page 7, I want to ask a couple of questions about family health teams. There were about 150 of them implemented, I think, across the province of Ontario during the last mandate of the government. How many of those now would have mental health counsellors attached to them? Secondly, as we go through fiscal 2009-10, what additional resources have been identified in your ministry's budget to add additional staff into family health teams, particularly mental health counsellors?

Mr. Ron Sapsford: As to how many current teams have them, I'll find that out for you. Each of the teams, as

they're created, is put forward on the basis of the needs in a specific community—

Mr. Jeff Leal: Right.

Mr. Ron Sapsford: And so, depending on where the family health team is located, mental health counselling may not have been part of their original request, but where that was identified as a need in a particular community, then the resources were put forward. But we can find out the specifics of how many numbers.

I mentioned in the OMA agreement, particularly, one of the things we've been trying to do, in return for increasing fees and giving economic consideration to the agreement, is begin to identify more clearly what the expectations for service provision are. The ministry views mental health as one of those core primary care services that should be widely available so that access to mental health services at the primary level is provided in many places. We have put some premiums forward in that agreement where physicians, either solo or in group, wherever they practise, are prepared to include primary mental health counselling as part of their general service delivery.

As well, in the family health teams specifically, we're making available, I think I said, about another 500 nurses, where those groups of physicians agree to provide these basic core services to supplement the team. So with an additional nurse, of course, they can provide more clinical time doing the kind of counselling that we want to see.

As far as the net number of family health teams themselves, the plan over the next two years is for an additional 50 to be found and funded.

Mr. Jeff Leal: Okay. I'd appreciate if you could get back to me with that. Thanks.

The Chair (Mr. Kevin Daniel Flynn): Helena.

Ms. Helena Jaczek: Mr. Sapsford, you've been able to tell us how many clients in various categories receive service. Does the ministry have any way of following these particular clients? I'm thinking in terms of health outcomes. I'm thinking of potential success, potential recidivism; in other words, people perhaps accessing a particular service and how many are able to lead mentally well lives subsequently. Do you have any figures in terms of progress through the system and health outcomes?

Mr. Ron Sapsford: Not in the kind of systematic way your question implies. There is isolated information. When you say the "outcome of care," in the area of mental health services, particularly as you get into the serious mental illnesses, what is a positive outcome is a matter of debate in many cases. So it's quite unlike what we do for public hospitals, for general hospital care: How many people went through for an appendicitis, had an appendectomy and came out basically cured of that particular acute care incident? It's relatively easy to keep track of it, and we do.

In many acute care services, the outcome measures are much more easily defined and results are easily collected. It's not the same thing in mental health. In fact, some of

the research that we're funding right now is on these very points: How do you measure successful outcome, and how do you track people through the course of a disease which sometimes can last 10 or 15 years but not be constant? There are times when the disease flares and then stabilizes and is managed, and someone can then go on for two or three years with reasonable support, and then the disease, in an acute sense, flares again—

The Chair (Mr. Kevin Daniel Flynn): Thank you, Mr. Sapsford. We're going to have to move on to Sylvia now.

Ms. Sylvia Jones: Just a follow-up question, actually. You talk about the clients you have been able to serve. I am quite interested in whether you are keeping stats on the waiting lists and the length of the waiting lists. Those are the people that, obviously, I have to deal with. Do you keep those stats?

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Mr. Ron Sapsford: No; in the kind of consistent, provincial way, service by service, we don't have the information systems to do that. In some, we would have waiting information for things like acute hospital admission in certain categories—

Ms. Sylvia Jones: Would the LHINs have any of that?

Mr. Ron Sapsford: No. If we don't have it, they don't have it. Maybe Anne can help to clarify some of it.

Ms. Anne Bowlby: One of the things we do have, through ConnexOntario—they actually do keep the availability, so we know the wait time for various services for substance abuse and problem gambling.

Ms. Sylvia Jones: By area?

Ms. Anne Bowlby: By area—by individual agency, actually. What we don't have are wait lists. We've talked about that for a number of years, and it's just too complicated because people sign up for four and five agencies, so we don't know what that actually means. But the wait time has given us some idea in terms of access and availability. We can get you those two numbers.

Ms. Sylvia Jones: Yes, I think the committee would find that helpful, actually. Thank you.

It sort of ties into the availability/access again, and it references what Jeff was raising with family health networks and family health teams. There are a number that I've spoken to that have it as part of their agreement but have been unable to access the staff. If you're providing that information, I would be interested in seeing just how many agreements are out there where they have been unable to find the health care professionals.

Mr. Ron Sapsford: In terms of their ability to actually find people?

Ms. Sylvia Jones: Yes.

Mr. Ron Sapsford: The hiring piece.

Ms. Sylvia Jones: Because they all see the value in having it in their agreement and having it as part of their network or their team, and then they post the job and there's no one available.

Mr. Ron Sapsford: Fair enough.

Ms. Sylvia Jones: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for your attendance today. The information that's been requested, you'll be forwarding on to the committee clerk?

Mr. Ron Sapsford: To the clerk, yes.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much.

MINISTRY OF HEALTH PROMOTION

The Chair (Mr. Kevin Daniel Flynn): Our next and final presenters for the afternoon are from the Ministry of Health Promotion. We've got Mary Beth Valentine, Cynthia Morton and Jean Lam, if you'd like to all come forward.

Ms. Cynthia Morton: Good afternoon. How are you?

The Chair (Mr. Kevin Daniel Flynn): Very good, thank you. If you'd like to introduce yourself and the people you have with you, and you've got 30 minutes, like everybody else. You can use that any way you like. If you would leave some time at the end for questions, the committee appears to enjoy that.

Ms. Cynthia Morton: Absolutely. My name is Cynthia Morton. I'm the Deputy Minister of Health Promotion. I have with me today my two assistant deputy ministers: Jean Lam, to my left, and Mary Beth Valentine, to my right. Jean will assist with any questions around programs and the substance of programs and what we're achieving there. Mary Beth focuses on strategic policy. So I'm surrounded by lots of good information sources for you here.

I do have prepared remarks, which I will go through quickly, and I believe we've provided you with a deck. Hopefully my remarks will reflect what you're also reviewing in the deck as we go along.

I first just want to thank and acknowledge the work of this committee and the effort of all political parties who are represented on this committee that has led, I think, to significant changes in mental health care and treatment over the last 25 years in this province. As a small ministry focused on health promotion, I think we're also looking forward to what could be a very exciting opportunity for renewed effort and focus on the mental health agenda in this province, and we're glad to be here today to share with you our work.

If I can, I'd like to take a few moments to describe to you the mandate of the ministry. We're a new ministry, a small ministry, and a relatively innovative ministry within government. We reflect, perhaps, what we could call a shift in the perspectives of the health care community and the caring community generally that started in the World Health Organization's meetings in 1986 in Ottawa and culminated in what was called the Ottawa Charter for Health Promotion. The Ottawa charter set out a vision for achieving an individual and community's physical, mental and social well-being. The charter emphasized that to really ensure and to achieve that well-being of a community and an individual, it required an intersectoral approach to the definition of what health meant; that it

went well beyond a health system to provide the kind of services and supports to a community and an individual that they would need to achieve that real state of wellness and well-being.

I think earlier today there was a reference made to the social determinants of health. Within the World Health Organization and, in fact, the mandate of the Ministry of Health Promotion, the social determinants of health are sort of our cornerstone of how we describe our mandate and establish our goals. When the World Health Organization described social determinants of health in the Ottawa charter—which we have a copy of, if you'd like it; it's a very interesting, innovative document. When they described what those social determinants of a community or an individual's health would be, they included fundamental outcomes like peace, shelter, education, food, income, a stable economic system, sustainable resources and both social justice and equity. Only when a community committed to achieving all of those things in an integrated fashion would the well-being and wellness of a community and an individual within it be guaranteed. To the extent that we have a mandate—a modest mandate, as a small ministry—we too have adopted those same goals. We approach our work and our mandate as an innovator and an incubator, and as the entity within government that is here, really, to try and promote that intersectoral integration across ministries and across communities in the province.

We have adopted a population health focus in achieving our work as well, which means that we direct our actions and our resources to those communities where the health status is the poorest, and as a result, the need for innovation and interventions is the greatest. As we adopt new strategies and we build new partnerships, we are paying the greatest attention to the poorest communities in Ontario: to the aboriginal communities on and off reserve, to children and youth in particular, working with our schools and our public health units and, increasingly, within the large ethnic populations where chronic diseases are rampant.

In the context of mental health, we see our responsibility as working across government and across communities to focus on the prevention of the illness and the promotion of healthy activities that make people more resilient, better able and better equipped to deal with issues of isolation, depression and addiction that can often lead to mental illness. We have worked, continue to work and will work more in the future with systems of public health, education, parks and recreation, children and youth services and so on. Our partners are First Nations leaders and community leaders, and we work with many of the NGOs who will probably appear before you during your deliberations. We've adopted the principle that mental wellness, self-esteem and social inclusion must be outcomes of almost every initiative that we fund within the ministry and every relationship that we have.

I'm going to give you some examples of how we reach the most at-risk communities, for want of a better word, in the context of three particular parts of our mandate.

One is the sports and recreation portfolio; another is our work in addictions prevention; the third is the area of supports we provide to the public health system, to families, to young parents and to infants through the public health programs.

In the context of sports and recreation, I think the evidence is pretty clear—and we can certainly provide you with some interesting articles to this effect—that children or youth who may not traditionally excel in school or, say, be members of a family where they live in a supportive home, are the children who we know, if they are allowed an opportunity to participate in sports and physical activity in their communities, can acquire resiliency, leadership and notions of success that other ways of engagement in their community don't allow them. So we have, within our sports and recreation programs, really focused on the inclusion of children who would otherwise be excluded from these opportunities.

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In this way, we do know that we are enhancing the connection between physical wellness and mental wellness, and we're trying to ingrain in children as young as possible the connection between the two and the skills that that connection will provide them for a lifelong ability to see themselves as valued and successful, in perhaps non-traditional ways. It also provides them with notions of team, discipline and success that they may not otherwise have.

When we solicit funding proposals for sports and recreation initiatives across the province, we do so with a requirement that children in poverty, children with special needs or disabilities, aboriginal children and newcomers to Canada will receive priority inclusion in this programming for these very reasons.

When these organizations that we fund report back to us on the year-end results, they must advise us on how well they have achieved these goals and what their plans are in the years ahead to continue to reduce those barriers for children, to give them opportunities for physical and mental wellness.

An example of one of those programs is a partnership between York University, the YMCA and the Canadian Mental Health Association that we fund called *Minding our Bodies*, that you may or may not have heard about. It was recently discussed in the media. It was an opportunity for people with mental illness who are traditionally excluded from team sports to come together and not only enjoy themselves but to acquire physical wellness as well as opportunities for bonding and success that they would otherwise not have.

I want to talk a bit about the services and the relationships that we have with the aboriginal communities on and off reserve.

We know that suicide rates for aboriginal youth, nationally in Canada, are five to seven times higher than for non-aboriginal youth, and for Inuit youth they're 11 times the suicide rate of the non-aboriginal youth.

The ministry is increasing its focus and its relationships with aboriginal communities both on and off re-

serve, with a clear focus on services to children and youth in terms of the sports and recreation portfolio. We have other services I'll tell you about shortly with respect to addiction and gambling, starting with teens. But for sports and recreation, we adopted a philosophy that we had to approach serving these communities and these children and youth in a way that would be welcomed and would be play.

We have across this province now a program called *activators*, that is in excess of \$2 million both on and off reserve, that provides to children and youth an opportunity to play safely in a well-supported environment. In one community we have an example of an *activators* program that began as a program for children and youth and now has been expanded to include their parents.

Parents are now coming to participate in a program with their children, as opposed to other nighttime activities they could have chosen. Parents are now realizing that their own physical wellness is something they can improve, as well as their children's, and they have quite explicitly said they would prefer to be there playing baseball with their kids than "perhaps going to the casino"; that's a quote from one of the parents in the community.

It is through these small, innovative, incubative opportunities for change that you can actually start creating best practices for a much more systemic change across communities. One of our goals is to champion best practice, not by telling communities what to do but by funding partnerships so that one community can demonstrate to another community what can make a positive difference. So while we are a small ministry, we very much believe that that incubation and promotion of innovation and best practice can make a very palpable and powerful difference in the highest-risk communities in our province.

I'd like to tell you now a bit about addictions and the work that we're doing in addictions.

I don't think I have to share with any of the members here today the work that the ministry has done on the smoke-free Ontario portfolio. It is, I think, for Ontario as a whole a very good success story. It has its challenges, one of them being young males who continue to just defy us in terms of how to reach them meaningfully. But we are undaunted, and we continue to work with the experts in the field of smoking cessation to try and reach into the area of addictions with young males in particular, but youth generally, in terms of the smoke portfolio. We are very community-focused on that initiative and we work with youth right across this province in very innovative ways to find new ways to reach youth.

Our hope and our intention is that the successes that we're having in the smoke-free agenda with youth are going to be our entree into a larger conversation with youth addictions generally. We're using our youth leaders and our youth experience of the last five years to have now a larger conversation with them around addictions and self-esteem.

We are also tackling the issue of mental health and addictions by integrating the work we're doing in one

portfolio with another. For example, while CAMH has clients walk through the door for one need to be met—a mental health need—we're also funding and partnering with CAMH so that they will offer those same clients an opportunity to start a smoking cessation program under the direct supervision of a physician; and that when those clients go back into the community, they can take with them the supports both of CAMH and access to, for example, our smoker's quit line, so that people will stay in touch with those patients, those clients, as they return to the community. We have those same supports offered in other hospitals across Ontario.

We also, for purposes of addictions and dealing with the consequences of people with addictions—whether that's other chronic diseases or injury prevention—fund these programs in 22 communities across Ontario, called Focus, which again some of you may know about because they're in your communities, or you have written to us very lately hoping that we would continue their funding, which we have. The intent of these community programs is really, one, that they have to at least focus one third of their activities on addiction outreach and prevention for youth, but also that they are, in the year ahead, going to be used as an opportunity to become integrated into a larger mental health strategy. They exist in 22 communities today; we're hoping we could replicate some of their strengths and successes across the province.

I want to give you an example of one of the successes that I think has great potential. It's located in Regent Park and is called the Regent Park Focus Youth Media Arts program. It's using young people's interest in that community in media to promote both healthy lifestyles and give them alternatives to street and gang activities. The Regent Park program provides these youth with opportunities to work either on a newspaper, which is online or in print, or to participate and host a weekly radio talk and music show. The youth themselves have described this program as something they consider as—I know it's hard when you hear an old person say it—a really cool alternative to being part of a gang or the street activities that they see around them.

The Focus program also links these same youths back into the education system through Pathways, which is sort of an alternative program for kids who have left that system. Many of the graduates from this program have returned, and they themselves now are mentoring others in the program. So for a small investment of less than \$100,000, we've made a huge difference—I think this program has—in the lives of many kids in a very high-risk neighbourhood. It's an example of one of the successes we want to incubate and share across the province. Without giving you the entire list of the awards that program has won, they've been recognized with an award from the mayor, from the CBC, from *Now* magazine and from many others for engaging youth in a very innovative model that addresses both violence and addictions in the community.

We are working, as well, in conjunction with the work that Deputy Sapsford has shared with you in terms of the

gambling prevention initiatives under way in this province. We do have some provincial initiatives that are based for population access overall, but our primary work, again, is in aboriginal communities, and we have many on- and off-reserve partnerships that we could share with you in more detail if you would like. But for the most part those kinds of activities, including access to community information centres, are training for front-line staff or funding the First Nations to train staff. We fund support groups and we provide educational materials for those support groups.

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Finally, I would like to just talk a bit about the work with the public health units that we do. The responsibility and mandate of the ministry is to oversee four mandated programs of public health units in this province. We share that responsibility with the Ministry of Health and Long-Term Care. The ones that we have responsibility for are focused on maternal and early childhood health, for the most part, and we very much believe that it is very important, even as a woman is pregnant, that she start to get access to services that can allow her to be screened and assessed for addictions and mental health issues that will face both her and, eventually, her child in their lives ahead. We then know that as a child grows, they are often exhibiting behaviour that may warrant a special examination of their physical and mental needs and, in fact, the health of their family. Such interventions can and should occur in a doctor's office, a preschool, through a public health visit or at a kindergarten. As a child becomes a young adolescent, we often see addictions, isolation and self-esteem become critical risk factors for those children, which must be understood and addressed by adults across many child-serving systems.

I would just like to offer a brief personal note. One of my former roles was children's commissioner in British Columbia, where I examined the lives and deaths of children at risk, and then I became a member of the federal parole board. So I met many young offenders who had not received services as children or youth, and whose needs were not fully understood nor identified in communities. I think that one of the opportunities this ministry has is to bring together all of the players across those communities and afford them the opportunity to share best practices and do more integrated planning, so that a child's and a family's needs can be put at the centre of everyone's focus.

I think I'll end it there. Thank you.

The Chair (Mr. Kevin Daniel Flynn): That was a really cool presentation. You've left us each about four minutes. Let's start with the government—or we can come back to the government. Do you have a question?

Mrs. Maria Van Bommel: At this point, nothing. No questions at this point.

The Chair (Mr. Kevin Daniel Flynn): Okay, wonderful. Sylvia?

Ms. Sylvia Jones: I wanted to go back to your smoking cessation programs. Would you be able to provide us

with some stats on your success rates, depending on which program they're tied into?

Ms. Cynthia Morton: We certainly can.

Ms. Sylvia Jones: Thank you. Sorry, I have another question.

The Chair (Mr. Kevin Daniel Flynn): Go ahead. We've got time.

Ms. Sylvia Jones: I am not familiar with the Focus program that you referenced—22, you said, across Ontario?

Ms. Cynthia Morton: Yes, 22. That's correct.

Ms. Sylvia Jones: So if you could give the committee a list of where those 22 are.

Ms. Cynthia Morton: Sure.

Ms. Sylvia Jones: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thanks, Sylvia. France, any questions?

M^{me} France Gélinas: Yes. Nice to see you. I haven't seen you in awhile.

Ms. Cynthia Morton: Yes.

M^{me} France Gélinas: The Ministry of Health Promotion—I mean, the name implies you're there for health promotion. Do you see a unique role for your ministry in funding promotion, prevention and early intervention in mental health? Is this something, as this committee works, that we should encourage to be located at your ministry? Or do you see it being a little bit everywhere?

Ms. Cynthia Morton: Health promotion is in a continuum of services that are being provided. I don't think any jurisdiction has quite sorted out where the lines are that you draw between one system and another, so they're grey. Where you move from prevention to intervention, for example, is a continuum, and from a community's perspective, it should be seamless. It shouldn't matter which ministry it's in.

From our perspective, we see our mandate as working across whatever ministry is our partner. So whether it's in this ministry or another, we still consider it a government-wide mandate to do health promotion. If it's in health or in children and youth or wherever the program is, we see it as an opportunity for us to leverage relationships across government and bring all of those players to the table to do that kind of holistic and integrated planning.

We're not looking to become a major service delivery kind of ministry. We're hoping we can continue to be the ministry that can incubate and promote innovation, evaluate best practices and share outcomes, with that kind of a focus. So it's not critical, for us to do our work, I guess would be the answer.

M^{me} France Gélinas: I appreciate the answer. I'm hoping once our work is done, we can put forward a strategy, and a component of that will certainly be promotion, prevention and early intervention. If I focus on promotion and prevention, is it reasonable to expect that your ministry would have the lead on that part of the strategy and, through the leverage of those relationships that you have with the other ministries, make sure that it gets implemented? I guess I'm trying to know—

Ms. Cynthia Morton: Yes, we definitely see that as our role. It's a role that we're playing now—not in mental health, because that framework is unfolding and that strategy is unfolding at this and other tables. But yes, it's absolutely the role that we want to play.

M^{me} France Gélinas: Unfortunately, my colleague hasn't had a chance to brief me on the Ministry of Health presentation that came before you, but is your ministry right now, or in collaboration with other ministries, working on a promotion/prevention mental health strategy? Is there work going on right now that we should know about?

Ms. Cynthia Morton: We're working with the Ministry of Health, the Ministry of Children and Youth Services and, to some extent, the Ministry of Education on these very issues around the integration of a holistic approach to mental health. I think Deputy Minister Sapsford spoke about that before we joined the table today.

M^{me} France Gélinas: Is this through the committee that exists, or is this through other tables, other relationships that you have?

Ms. Cynthia Morton: It is work that we've always been engaged with, because we all have the responsibility at a service delivery level to do better with the mandates that we've been given. I think what is lacking is the overall strategy for the future, and that's what we're hoping this table and others will provide. In the interim, we really do believe that mental wellness is a fundamental part of almost everything that we do, and that's what we expect of the programs and the partners that we fund.

M^{me} France Gélinas: I certainly support your strategy, where you put the resources with the communities with the highest needs—newcomers, First Nations. I was just surprised that francophones were never mentioned. Is there a reason for this?

Ms. Cynthia Morton: We're basing our interventions on health status, so we're going to those parts of the province where health status is the poorest. To the extent francophone communities are fitting within that definition, they will definitely be part of our target communities.

M^{me} France Gélinas: The way that you do your assessment to identify the communities—is this something you can share with the committee? I would be interested in knowing what those communities are, but I would also be interested in knowing the process for the evaluation so that you know one community is needier over another.

Ms. Cynthia Morton: Sure, we can give you that. It's essentially a cross-mapping of a number of indicators that we've put together. Knowing we can't be everywhere, we have to prioritize the ones that we go to, depending on that mapping.

The Chair (Mr. Kevin Daniel Flynn): Thank you, France. We're going to go back to the government. Jeff and then Liz, I think.

Mr. Jeff Leal: Ms. Morton, you finished your presentation touching upon young offenders. Could I just explore that a minute with you? There are some people who share the philosophy that dealing with young offenders through extensive jail sentences is the be-all and end-all to try to address their problems. I think others have different views, because many of them have suffered from various forms of mental illness. Based on your experience, if you could shed a little bit of light on this one for the committee, I'd really appreciate it.

Ms. Cynthia Morton: I think the greatest indication of a community's failure is when a young offender graduates to the federal system, where they do even more time, spend even longer in jail and are even harder to reach in terms of rehabilitation. The evidence is clear—it's not my personal opinion—that if you want to ensure that young offenders do not become older offenders, you must intervene early through a supportive and rehabilitative framework. I can give you all kinds of studies that have shown over time the consequences of adopting one approach over the other and the success rates of both.

Often, though, you will see young offenders, especially with mental illness—they were living in the community, self-medicating mental illness through addiction. Often, sadly, they are receiving their first treatment in a correctional facility. So to some extent, it may be the very best place they can be until they're stabilized and allowed to return to the community, with a new sense of how to manage their illness with supports in place—because a lot of these kids live underground. They're very hard to find. They're homeless, they're transient, they're high-risk, and they may be living in crime. They are the hardest to reach. Sometimes, the first time a community will interact with those kids is in a criminal court. So their first opportunity to get treatment could be in a correctional facility.

I think the best thing you can do for those kids is get them plugged in to their community and give them an opportunity to be successful, because that's what's going to keep them out of jail: success in their community. I've seen too many examples of failure, and I've seen very good examples of success—and they never come back. They never want to come back.

The Chair (Mr. Kevin Daniel Flynn): Thank you. To Liz for the final question today.

Mrs. Liz Sandals: Yes. In the deck that you gave us on page 10, there's a comprehensive framework for a mental health and addiction strategy that you've included. I wonder if you could tell us a little bit about where that particular framework came from, how it was developed—because there isn't anything to sort of place it, in terms of where did it come from. Is that from your ministry or from some other source?

Ms. Cynthia Morton: It's just our advice.

Mrs. Liz Sandals: It's your advice. Okay.

Ms. Cynthia Morton: It is a reflection of a population-health, social-determinants-of-health approach to identifying the context for mental illness in the larger context of a community's role and of wellness.

Mrs. Liz Sandals: So it would be your recommendation, then, from the point of view of your ministry, looking at health promotion, that as we are looking at a mental health and addictions strategy, as we're doing report writing, this might be a bit of a checklist to see if we've included the elements that are framed here on this slide.

Ms. Cynthia Morton: It is our advice, and it's essentially a model of how the ministry approaches the same issues.

Mrs. Liz Sandals: Okay, thank you. That's helpful. I just wondered where that came from.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for your attendance here today.

COMMITTEE BUSINESS

The Chair (Mr. Kevin Daniel Flynn): That's the final delegation, but I would like to draw the committee's attention to a letter and some information we received from the Office of the Auditor General of Ontario. The last paragraph of that says—he provides a lot of information, a lot of background, but he also asks if we would be interested in an overview of the findings and observations. He'd be pleased to provide a short briefing.

I'm assuming the answer to that would be yes, but I just wanted to make sure that the committee agreed with that. Okay.

Ms. Sylvia Jones: Chair, for future presentations that come forward, particularly, I guess, related to the ministries, can we ask that they not use their 30 minutes so that we have an opportunity for a bit of discussion?

The Chair (Mr. Kevin Daniel Flynn): We can suggest that, perhaps.

Ms. Sylvia Jones: Thank you. Strongly?

The Chair (Mr. Kevin Daniel Flynn): Strongly—as strong as I get.

Mr. Bas Balkissoon: Can we get the reading material ahead of time so we could craft some questions?

The Chair (Mr. Kevin Daniel Flynn): That's a good idea. We'll try to accommodate that.

Mr. Bas Balkissoon: Because I think the Auditor General sending us his stuff will prepare us, and when he comes here, we would have a better discussion.

Ms. Helena Jaczek: If it's here, yes.

Mr. Bas Balkissoon: Yes, but when he arrives here, we'll have a better discussion.

The Chair (Mr. Kevin Daniel Flynn): Oh, I see. Okay. He didn't send the stuff, actually. Susan was being modest. She provided the stuff—which probably isn't a good thing to say at an addictions subcommittee, but—

Mr. Bas Balkissoon: That's a good idea. It's a very good idea for the future.

The Chair (Mr. Kevin Daniel Flynn): Okay, we will work to ask them to see if they can leave some time for questions.

We're adjourned. Thanks for your attention this afternoon.

The committee adjourned at 1801.

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MH-6

ISSN 1918-9613

Legislative Assembly of Ontario

First Session, 39th Parliament

Assemblée législative de l'Ontario

Première session, 39^e législature

Official Report of Debates (Hansard)

Wednesday 6 May 2009

Journal des débats (Hansard)

Mercredi 6 mai 2009

Select Committee on Mental Health and Addictions

**Mental health
and addictions strategy**

Comité spécial de la santé mentale et des dépendances

**Stratégie sur la santé mentale et
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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

SELECT COMMITTEE ON
MENTAL HEALTH AND ADDICTIONSCOMITÉ SPÉCIAL DE LA SANTÉ
MENTALE ET DES DÉPENDANCES

Wednesday 6 May 2009

Mercredi 6 mai 2009

The committee met at 1604 in committee room 1.

The Chair (Mr. Kevin Daniel Flynn): If we can call this meeting to order, ladies and gentlemen. Thank you for your attention, and excuse my being a little tardy.

MENTAL HEALTH
AND ADDICTIONS STRATEGY

MINISTRY OF ABORIGINAL AFFAIRS

The Chair (Mr. Kevin Daniel Flynn): The first delegation today is from the Ministry of Aboriginal Affairs, and we've got Lori Sterling and Alison Pilla with us. The floor is yours. We've allocated 30 minutes to each of the ministries that have come forward. You can use that time any way you see fit. It would be nice if you would leave a little bit of that time near the end for some questions, though.

Ms. Lori Sterling: Absolutely. Thank you very much.

The Chair (Mr. Kevin Daniel Flynn): And if you would introduce yourself for Hansard as well.

Ms. Lori Sterling: Yes. My name is Lori Sterling, and I'm the deputy minister at the Ministry of Aboriginal Affairs. I have with me my assistant deputy minister for strategic policy and planning, Alison Pilla.

I'd like to begin by thanking the select committee for the opportunity to make the presentation today and acknowledge the effort that the committee is putting into the question of mental health. As I hope you'll see when I go through my slide deck presentation today, which I hope you all have in front of you, the question of mental health and addiction is an extremely pressing problem for aboriginal people in Ontario.

Before I actually take you through the statistics and the programs, I'd just like to spend one moment telling you a bit about our ministry and what our mandate is.

The ministry is very new, created only in June 2007, and was the result of a recommendation of the Ipperwash report, headed up by Justice Linden. The intention of this ministry is to create bridges and build relationships and trust with aboriginal people in Ontario and the government itself. We remain a very small ministry, under a couple of hundred people. I think I heard the secretary call us small but mighty, because our mandate is very broad; that is, to reduce the socio-economic gap, ultimately, between aboriginal people and non-aboriginal people in this province. We don't do that by actually having a range of programs in the ministry itself; we do

that by collaborating and coordinating across all ministries in the government. We also set priorities and we track the progress of aboriginal people in the province.

We also have a mandate to enhance awareness about aboriginal culture and aboriginal people, and to promote best practices by the province on consultation and accommodation of aboriginal rights.

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We also act as "one window" for aboriginal people when they seek to access government services. That's not to say that we close down pre-existing relationships, but for many aboriginal people there are a variety of ministries that may have programs relevant to them, and our job is basically to help them navigate the system.

Then, finally, we work extensively with the aboriginal leadership by, first of all, responding to their immediate needs, and also by ensuring that they become part of the process within government, including most recently the introduction of new legislation.

So that's the mandate of the ministry.

What I'd like to now do is turn to the deck itself and very quickly take you through some of the highlights of the deck. I appreciate that you may want to ask questions, and so I will skip lightly through the pages of the deck. As well, I won't go anywhere near the appendix, which provides far more detailed information about the topics in the deck.

If I could ask you to please turn to page 4, what I'd like to do is start by briefly describing aboriginal people in this province demographically and then describe them from a socio-economic perspective. I think the statistics tell a very sad and sorry tale about the socio-economic plight and the mental health situation, in particular, of aboriginal people.

In Ontario, we have the largest aboriginal population by province in the entire country: 21% of the entire aboriginal population is in Ontario. They are a small part of the overall population, only 2%, but you'll see from the data that their needs far outstrip their actual percentage of the population in Ontario. What is a growing trend is the fact that aboriginal people are increasingly leaving the reserve. Now, 60% of all aboriginal people live off-reserve, and most of them are in large urban centres or small towns.

What is most conspicuous about the demographic population is that it's extremely young and growing very quickly; just under a third of the population is actually 14

years old or younger. So we like to say in the ministry that this is the workforce of the future, given these demographics.

As well, from a socio-economic perspective, they are consistently at the bottom even amongst disadvantaged groups in our society. The unemployment rates are triple those of non-aboriginal people, the income rates are less than two thirds, and one statistic that really is something that has to be remedied is the education rate. At this point, almost 40% of all aboriginal people in this province do not graduate high school.

If I could ask you to turn to page 5, you'll see there's a map of the province. The map has got print which is probably too small for most of us to read right now, but what I can tell you is that it's colour-coded by political-territorial group. There are four political-territorial groups in the province, and then a fifth group called independents. As you can see, these are the First Nation communities and they are literally all over the province, including the far north.

Thirty-three communities in the far north are what we call "remote," meaning there is absolutely no road access at all. To get to those communities, you have to fly in, or sometimes there's some access through ice roads in winter. The ice-road season is generally from early January/beginning of February through to March, depending on the winter. This winter, in fact, I was on one at the end of November, but that was unusual.

The First Nations in Ontario have very sophisticated what they call "political-territorial organizations," and all First Nations belong to the Chiefs of Ontario. I tell you this because when you go out and do your consultation, we would highly recommend that you engage with the Chiefs of Ontario and with the provincial/territorial organizations because they have given a lot of thought to questions of mental addiction amongst their own population.

I'll turn now to the next page. These are some statistics related to mental health amongst the aboriginal population. We've got suicide, depression, emotional disorders and FASD, fetal alcohol syndrome. I'm only going to mention two. The first is the suicide rate, especially amongst aboriginal children and youth. The community of Pikangikum has the world's highest youth suicide rate. It is part of the Nishnawbe Aski Nation, which is the group that runs along the northern part of this province and which itself has, in various communities, high youth suicide rates.

The rates are astounding, especially when you think that the communities themselves range in size from 250 to 2,000. So Pikangikum, which is a large community of 2,000, has had 175 youth suicides in the last five years. I went this year into another community, called Wabasseemoong, which is close to the Manitoba border, and it turned out my timing was the day after a youth suicide of a crown ward who had just returned. The kids go off the reserve. They get flown into towns for grades 10, 11 and 12, and they often come back, and sometimes they come back as crown wards. There was a youth suicide the day

before, and the one thing that struck me was that the entire community, given its size, feels the death. The visitation is in the community centre, so even people who didn't know the young girl were all in a communal bereavement mode. So it's a really significant mental health issue amongst the aboriginal population.

The other social indicator that I just wanted to mention is addictions and the related fetal alcohol spectrum disorder, which of course also has implications for their graduation rates, which I mentioned earlier. Addiction within the aboriginal community is not just an alcohol kind of addiction, but especially amongst the youth now—although I don't have hard data, you'll hear it all the time from the chiefs—there's extensive use of prescription drugs. There's a big sign when you enter one community that says, "No lacquer." To be honest, when I went to it, I thought it might be a typo, but in fact it's paint lacquer, which is used as part of substance abuse. Then, in the far north, when you go into those communities, they always have locks on their diesel fuel that's used for energy transmission to prevent theft because there's also substance abuse associated with diesel fuel. This kind of abuse is also found in even the remote communities where these substances actually have to be flown in and there's no sort of road access or entry.

When you chat with the social work experts in this area, they will always tell you that when it comes to mental health issues in the aboriginal community, the priority should be children and youth, and it should be both the suicide and the addiction aspects of mental health.

I'm going to quickly move on to some of the current challenges. They feed into our suggestions for areas in which you might want to do further research.

I can't, on page 8, talk about current challenges without talking about the fact that the responsibility is shared between the federal government and the provincial government. This leaves gaps. The federal government largely funds on-reserve health care, and there's a commonly held view that they fund it at a lower rate per person than the rest of the province. You will see, however, that there are provincial programs which are on-reserve, but the primary responsibility on-reserve is with the federal government.

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The second is that there is a current challenge in that there are very few aboriginal people trained to deal with mental health care. I think what the communities will tell you is that the people who stay locally are people who are born there. It's no different than, for example, what you hear about doctors in some of the communities. In the mental health area, the people who come in to help out are there on locums or on apprenticeships. In one community, they didn't have any psychiatric assistants on reserve, so they were doing psychiatric interviews by telephone once a month. Kids would line up in a waiting room to get access to that kind of care. So it's really important that there be skills training that would enable local people to be trained on mental health issues.

The third is the cultural aspect of whatever mental health care training does take place. Aboriginal people tell you that you have to recognize the uniqueness of their culture, their desire for a more holistic approach and always community involvement in the actual program.

Other problems related to aboriginal people you might find among other groups in society as well, and those relate to poverty; for example, inadequate housing and absence of money to pay for certain kinds of treatment are also endemic to the aboriginal community. Even food-related things, which might impact on mental health, are particularly problematic. When I was up in the north, it cost \$10 for six apples at any point in time because of the cost of transportation.

Finally, you can't leave the question of current challenges without for a second mentioning the residential school experience. What we are learning is that it in fact has an intergenerational impact on these communities and any mental health care has to take that into account.

Turning to what we currently have in Ontario—appreciating that I'd like to leave some time for questions, I'm not going to take you through the funded programs that we have—you will notice that there are a few Ontario programs, but they are largely run by individual ministries. What you don't see in our deck is a government-wide, comprehensive mental health strategy for aboriginal people. Then the other point to be made is that when you combine what's available from Ontario with what's available from the federal government, there doesn't seem to be a lot of coordination between the two.

Could I ask you now to turn to "Other Jurisdictions"? The sitting of this committee is very timely because, in fact, many of the other provinces have had internal research and committees looking at this issue, and in particular with respect to aboriginal people, what you see on the page dealing with the jurisdictional analysis is that Alberta, Manitoba, British Columbia, Saskatchewan and Nunavut have all recently looked at the question of what should be the component parts of an aboriginal mental health strategy. We would encourage this committee, when it engages again outside, to have discussions with some of the other jurisdictions. In the appendix you'll see some more details about what those other jurisdictions have decided to do about the issue.

That brings me to the question of what we've called gaps and opportunities. I think it's fair to say that the gap that comes to mind first and foremost is the absence of an aboriginal-specific mental health strategy that runs across the government, through all the various ministries that have a role. You'll be hearing from many of them in the course of these hearings and have a forum to come together to deal with aboriginal mental health issues.

The second one that we've noticed as a gap is programs to enhance the training for aboriginal people, and I mentioned that earlier. I also mentioned earlier the need for coordination with the federal government.

Finally, one issue in the gap, which I'm sure you will hear from various ministries, is the need for collection of information and data and greater sharing of that information amongst the various agencies.

That brings me to the conclusion.

What I'd like to suggest is that this ministry is not really the main repository of expertise on aboriginal mental health issues. You will find that expertise within aboriginal communities themselves. In particular, the Chiefs of Ontario have indicated that they would like to meet with you, outside government, within government. Of course, you're meeting with the Ministries of Health and Children and Youth Services.

While we may not have the main expertise on mental health, we can speak on behalf of aboriginal people with respect to what they see as their priorities. What we have learned is that they would like a specific program that takes into account their unique circumstances. That program would include:

- questions of funding: Are they getting adequate or equitable funding?

- the training point;

- the need for recognition of their linguistic and cultural differences. When you go into the north in particular, you will see that a large segment of the community still does not speak English; and finally,

- the ability to track data and monitor the progress that's made.

I understand that you're also interested in going into a community. We would recommend that you take a trip up to the northwest part of this province for an example of a community that is more remote but nevertheless has significant mental health issues, and then visit another community, in the south, that's closer to an urban area, which has access to more mainstream resources but which has nevertheless chosen to develop more aboriginal-specific programming within their own community.

Those would be my opening remarks. I'm open to any questions you may have.

The Chair (Mr. Kevin Daniel Flynn): That's great. You've left about nine minutes, so we'll start with Christine.

Mrs. Christine Elliott: Thank you very much for your presentation. I'm sorry I wasn't able to be here for the beginning. It's very informative, and it's very helpful to know that the chiefs would like to meet with us, because we would very much like to discuss with them the problems in their specific communities. I would hope that you might be able to help us facilitate that and perhaps offer us some suggestions on specific communities that you think it might be helpful for us to visit.

I really just had one question, and you may have covered it already; I'm not sure. Is the ODSP operational in aboriginal communities? I just don't know.

Ms. Alison Pilla: The disability plan or the drug plan?

Mrs. Christine Elliott: Disability, ODSP.

Ms. Alison Pilla: Oh, yes. Under the 1965 welfare agreement, the province delivers all social welfare programs on-reserve, and that would be both the general welfare assistance program and the disability program.

Mrs. Christine Elliott: In your experience, is it as easy to receive ODSP benefits in the south as it is in the north, in some of the communities? Do people have greater difficulty accessing ODSP?

Ms. Lori Sterling: I'm not sure if the Ministry of Community and Social Services, which actually delivers the program, is appearing before you. The concerns that we generally hear about ODSP relate less to the delivery to the individuals on-reserve and more to the question of cost-sharing between federal and provincial for the delivery. But again, I'd have to defer to the Ministry of Community and Social Services.

The Chair (Mr. Kevin Daniel Flynn): I think they're up next, so that would be timely.

France, you've got about three minutes.

M^{me} France Gélinas: I was just curious to know: In the work of your ministry, do you ever do any kind of inventory or mapping of the services that exist that would include the mental health and support services that exist in the different First Nations communities?

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Ms. Alison Pilla: It really depends on the particular policy that we're looking at at the time. For instance, on the mental health and addictions piece, it hadn't been a focus for us at this point, being a new ministry. We obviously did some work for this presentation, but we haven't undertaken a full analysis of all the programs. Ministries have done their own work as to what programs are in place and where they are. That's a good question, and maybe some work needs to be done.

M^{me} France Gélinas: Through your ministry, do you know, and can we have access to, a little bit of the demographics of the different First Nations communities, as in how many residents—

Ms. Lori Sterling: Yes. We can absolutely provide you with the demographic information for every First Nation community in Ontario.

M^{me} France Gélinas: I'm not sure if we have finished our selection; we will be going to First Nations communities for sure. Once we've made that selection, if we share that with you, you would share all of the social demographics that you have?

Ms. Lori Sterling: Yes, and we can help facilitate the actual trip, if you'd like.

M^{me} France Gélinas: Very good. Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you, France. We've got two speakers from the government: first Maria, then Jeff.

Mrs. Maria Van Bommel: Thank you very much for this information. I'm just looking at the information you gave us on page 4, and the map, of course. The information you gave us is sort of province-wide, but my gut tells me that there are differences between the northern part of the province and the southern part, and also a difference between on-reserve and off-reserve. Is there any way of getting some stats from you to give us some ideas? Like I said, these numbers are province-wide, so when you talk about who completes high school and that sort of thing, I'm just wondering if there's greater opportunity for completing an education in southern Ontario than in northern Ontario, or whether being on-reserve or off-reserve gives advantage in any way at all to some of these things.

Ms. Lori Sterling: The Ministry of Education is in the process of collecting data that would be of assistance to you. What is interesting is that, in the north, all the reserve students actually go off-reserve to finish high school. Just capturing who completes high school in a town is not going to give you the on-reserve/off-reserve—

Mrs. Maria Van Bommel: In my own riding, we have situations where the elementary school is on-reserve and the secondary is off-reserve.

Ms. Lori Sterling: Yes. I think that we can look into the issue and get back to you.

Mrs. Maria Van Bommel: Okay. Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Maria. Jeff?

Mr. Jeff Leal: Deputy, thank so much for your comprehensive presentation today.

Jurisdictional wrangles, I think, have had some real repercussions for First Nations communities in Ontario. Attawapiskat and Kashechewan are two good examples. Has there been any move for INAC to provide funding instead, getting out of the way of delivery of services and giving the province those dollars? Because the province is in the best position to deliver dollars, whether it's health care, education or financial resources to develop mental health programs. Secondly, the need to incorporate—for example, our First Nations communities use healing circles as a way to address individuals or communities that have mental problems and associated difficulties, so to bring that sort of tradition into the way that we approach providing mental health services to our brothers and sisters in our First Nations communities.

Ms. Lori Sterling: First, on the question of the federal-provincial divide: At this point, the federal government provides education, for example, on-reserve, and I don't know that there has been any indicated willingness for either the provincial or federal government to actually have the province take over delivery. With respect to social assistance, I think I mentioned earlier, it's actually delivered by the province. And in the area of health care, as I say, it's largely delivered federally on-reserve, but there are some supplemental provincial programs. I'm not aware at this point of an initiative that would allow the province to do all the delivery.

The second question was about holistic approaches to healing. There have been efforts to try to become more holistic, more in tune with the community needs. I think this is an area where the First Nations would like to see more work done.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for your presentation today. It was a pleasure having you.

Ms. Lori Sterling: Thank you very much.

MINISTRY OF COMMUNITY AND SOCIAL SERVICES

The Chair (Mr. Kevin Daniel Flynn): Our next speakers this afternoon come from the Ministry of Community and Social Services: Lucille and David.

Thank you for attending today. Make yourselves comfortable. You've got 30 minutes, like everybody else. If you would leave some time at the end, I know the committee would appreciate that for any questions they may have. If you would introduce yourselves for Hansard, that would be helpful, and the floor is all yours.

Ms. Lucille Roch: Great, thank you very much. My name is Lucille Roch. I'm the Deputy Minister of Community and Social Services accessibility in the Office of Francophone Affairs. I'm accompanied here today by David Carter-Whitney, who's the assistant deputy minister, policy, in the Ministry of Community and Social Services. Thank you very much for giving us the opportunity to appear before you today.

From our perspective, it's really great that you're taking a kind of whole-government approach to this issue, because it's obviously one that requires such an approach. I'm assuming you all have a copy of our slide deck. You'll see from the outline on slide 1 that we're going to provide you with a pretty high-level overview of the intersections between our programs in social services and supports and people with mental health and addiction issues. Obviously, if you want more information, we'll make ourselves available to you or provide you with additional information after we leave here today.

As you can see from slide 1, I'll give you a bit of an overview and then we'll address more specifically three issues that we think need to be looked at. We'll make some references to some case studies that we have attached as part of the addendum to the slide deck.

Slide 2 gives you an overview of the ministry's vision and mission. As indicated here, we try and help people build resilience and remove some of the obstacles they're facing as they're attempting to participate in community life.

I'd just like to say that the Ministry of Community and Social Services focuses on vulnerable adults. Some of you may recall that at some point this ministry included all children and family community support services. In 2003, the Ministry of Children and Youth Services was created, so we've focused on adults' programs and services.

Slide 3 of the deck gives you an overview of our services and supports. We provide income and employment supports through the Ontario disability support program and the Ontario Works program. Those are the two programs that people refer to when they talk about social assistance or welfare.

If you look at the Ontario Works description, there's a reference here to the addiction services initiative, which is a program that's provided in about 15 communities and three First Nations in the province. It's provided to recipients of Ontario Works and ODSP. Through that program, we provide some intensive supports to people who are barriered, in the sense of being able to access employment because of their mental health issues and addiction issues. We've implemented it, as I referenced, in about 15 municipalities and three First Nations.

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As you can see from that slide as well, we provide services for adults with developmental disabilities, and we also provide other community services such as programs for women who are fleeing domestic abuse, homelessness and interpreter and intervener services. We also have a unique partnership with other ministries and about 14 aboriginal organizations and First Nations as we oversee the aboriginal healing and wellness strategy, which focuses on reducing family violence and improving the health and healing of aboriginal people.

I'd just like to mention as well that the ministry is responsible for the accessibility for Ontarians with disabilities. We're working with stakeholders and the community to develop standards to implement that legislation, and we're also responsible for the Family Responsibility Office, which provides neutral enforcement of family support obligations.

So you can see from this description that we're often in the position of responding to people's needs, people who are quite vulnerable in terms of, they're facing a crisis and they turn to this ministry or the programs and supports that the ministry provides to help them work through that crisis. Often, as we've found, many of them come to us in a way that they might not have had to if supports and services had been available earlier in their situation.

On slide 4, I just want to reference a few issues around clients' accessing social assistance and employment supports. We have a number of programs where the prevalence of individuals with mental health and addiction issues is quite high. The first two programs I'd like to reference are ODSP and Ontario Works, and as you can see from slide 4, over half the ODSP recipients are people with a mental health disability. That means that the nature of their illness is prolonged. To get on ODSP, your illness needs to have lasted at least a year, and it has to significantly impact on your activities of daily living. So we think there are likely many more people on Ontario Works, for example, whose mental health or addiction problems are currently either undiagnosed or they're not quite severe enough yet to qualify for ODSP, so the challenge is to try and support these people before their conditions worsen.

The addiction services initiative that I mentioned serves a very small proportion of our total Ontario Works caseload. It's less than 1%.

Also, I'd just like to mention that research does suggest that between 40% to 75% of individuals with substance abuse problems have co-occurring mental health issues. So, although it might be difficult for us to prove this empirically, we do believe that early identification and prevention of mental health and addiction issues could have an impact on reducing the proportion of people who require income assistance through our programs.

Slide 5 also references additional social service programs that are offered through the ministry, and these programs also see a pretty high proportion of individuals who are affected by a mental health and addiction issue.

In developmental services, where we provide services and supports to adults with a developmental disability so that they can live in the community as independently as possible, there are about 30% to 38% of individuals who have what is referred to a “dual diagnosis.” That is, they have a developmental disability and they also have a mental health issue.

In our domiciliary hostel program, we provide permanent housing with limited supports for individuals who need assistance with activities of daily living. That could be a physical health issue, it could be a mental illness, it could be a developmental disability or it could be a substance abuse problem.

Recently we did a survey with the Ministry of Health and Long-Term Care, and 73% of the survey participants reported having been diagnosed with at least one mental health issue, and 52% reported being diagnosed with a serious mental health issue.

In our violence-against-women programs, a recent survey of women in women’s shelters identified 29% of the women reporting substance use issues, and in our homelessness programs, recently a study undertaken by the city of Toronto to collect better data concerning the homeless found that approximately 86% of homeless people had a lifetime diagnosis of either mental illness or substance abuse.

As well, in our consultations that we held last summer with the aboriginal communities, as we were talking about the aboriginal healing and wellness strategy, most of the aboriginals identified the need for expanding programming in mental health as a priority for them as we look to the future.

As you can see, our ministry doesn’t fund mental health services directly. However, our programs have significant numbers of individuals with mental health and addictions issues, and in some cases, we try to provide them with the supports that they require.

Obviously, we work quite closely with the Ministry of Health and Long-Term Care and the Ministry of Children and Youth Services, as we try to link our programs, I’m thinking in particular of developmental services, for example. You have children in the care of the children’s aid society who may have a developmental disability. As they exit that system, we’re working hard with the ministry. We’re not there yet, but we’re in the process of developing protocols so that we’re in a better situation to help these people transition to the adult system. So there’s a fair amount of work that goes on at the local or regional level.

I’ll turn it over to David to highlight the three themes that we’d like to share with you.

Mr. David Carter-Whitney: As you’ve heard, MCSS has been mandated to provide certain types of support and assistance, and often these are programs that have very specific criteria, eligibility and assessment. Yet what we know is the mental health and addiction issues can’t be addressed separately from the broader context of people, and they don’t necessarily present neatly in package around the types of programs we offer.

Generally, individuals who experience mental health and addictions issues probably require a continuum of care and support that recognizes a variety of needs. That could be community-based services, income and employment, adequate housing, addictions—other things. We’ve been making progress. Social assistance programs, in their origins, were simply that: financial assistance. Now, as you hear, we have a number of things that are provided in addition to the basic income supports, but there are still gaps in the continuum, particularly a lack of community-based services and an insufficient quantity of services.

The scenarios you’ll see in the appendix—there’s a series of stories. These are actually real stories about real people who the ministry has interacted with in some way. We thought it would be helpful to convey in a context that reflected what we are experiencing in trying to serve the public and some of the kinds of stories that we have seen. If you look at page 11, the story of Maria is an example of an addictions services initiative success. This is someone who received support around her addiction and assistance in setting personal employment goals and in getting access to a range of community services to assist working successfully toward those goals.

I will say that our examples aren’t all happy endings. We decided that to be realistic, we really had to reflect that there are many people where the challenge is beyond what we can offer.

In this particular case, with ASI, which we referred to several times, there are significant gaps that limit the effectiveness of the program. We currently have it available in 15 communities. In addition, in some communities there are gaps: for instance, the access to family physicians for referral, diagnosis and treatment or even access to supports such as supportive housing.

To make really significant progress around mental health and addiction, we need to address the gaps in the continuum of care and particularly community-based services. In that role, we’ve increasingly worked with municipalities. The ministry delivers many of its programs through the municipalities, which actually function to bind together certain types of supports—I think this is an area that has been under discussion—of continuing to build and expand to let local partners knit together those things which ministries sometimes struggle to do.

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The second issue we’ve identified is around the need for a person-centred approach. A continuum is a start but doesn’t go far enough. Services and programs need to be coordinated and integrated in a way that puts the person at the centre and responds to their changing needs and circumstances throughout recovery. A person-centred approach has to respond to the cultural and linguistic background of the individual, and again, in Ontario, an increasingly diverse society, there are challenges around that. We also face challenges in ensuring that the right services are available in the right places in French.

Transition periods in a person’s life from children and youth services to adult services, or as an individual ages,

put a spotlight on how services may not be provided in a person-centred approach as well, that people pass certain age marks, and their eligibility and access to certain types of programs change.

Also, for individuals with a developmental disability, there are stresses for their aging parents and caregivers. This is particularly the case when there is a dual diagnosis. It could be undiagnosed, or if it's inadequately addressed, then mental health issues can result in really severe behavioural changes. The story on page 12, Brian's story, demonstrates some of these issues. This is an individual who actually assaulted a family member and was charged. There are provisions in the criminal justice system to ensure that he isn't found criminally responsible, but there weren't appropriate specialized medical and mental health services and treatments for his needs in the community, so he ended up in a forensic mental health facility, due to a lack of appropriate long-term residential supports and assistance for him and his aging parents.

MCSS works with partner ministries—the Ministry of Health, Ministry of the Attorney General, correctional services and Ministry of Children and Youth Services—on the intersections between justice, mental health and dual diagnosis, but we need to continue to make progress on making our programs work well together in response to the individual.

Many of our most important supports also can't be directed from policy at Queen's Park. We have programs where the decision-making is local and responsive to the individuals. One of the challenges, one of the incentives to make sure that these local decision-makers, whether they're in the municipality, provincial or federal office, whether they're in a school board or the LHIN or another third party, is that there's a protocol that pushes them to work together and make decisions that bring people together and reflect the whole person.

The third issue is really around the need for early identification, prevention and recovery. You've heard that many of our programs actually step in at a point when someone has reached a point of crisis, which one could argue is in fact we often are there because the system has failed the individual at an earlier stage.

You've heard from other ministries that the justice system often becomes the entry point into the system for individuals, and this means that, by this point, issue identification is expensive and punitive and often too late in some cases. From our perspective, early identification and prevention are really a key to improving outcomes for individuals and reducing the number of individuals who access inappropriate or high-cost judicial or emergency services, and particularly for us, we see that reflected in homelessness.

In the scenarios, we've included on page 13 a story of Jeff, and this is a chronically homeless individual. This is someone who had a history of childhood abuse, which led to undiagnosed and untreated substance abuse and to a heavy use of emergency hostels and emergency hospital services. As described, you'll see he has

achieved some level of stability through our Hostels to Homes program, but you can imagine how differently his story might have read if his issues had been identified and addressed earlier in his life.

I think there's a tendency to think that this is a medical system issue; it isn't just a medical system issue. It can't respond to all these needs. People like Jeff need encouragement and support at various stages, in various places in their lives, and not simply a medical intervention.

Ms. Lucille Roch: To summarize, we do invest a significant amount in supporting individuals with mental health issues, and from our perspective, the key to some of these issues might be to look at a continuum of care and support, adopting, perhaps, a more person-centred approach to mental health and addictions, and focusing on early identification, prevention and recovery.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much to both of you for your presentation. You've left about three minutes for each of the parties, starting with France.

M^{me} France Gélinas: Thank you for your presentation. I'd like a little bit more info on two of the programs that you've talked about. The first one is the addiction services initiative. Are any of those 15 communities in the north? What's the name of the program so I can recognize it? That means nothing to me.

The second is the domiciliary hostel tenants. Here again, if you could give me some examples of how it works and, if it's possible, look at it through the client's perspective: What would it look like for them?

Mr. David Carter-Whitney: The addiction services initiative is actually the name of the program. It is a program you access through the Ontario Works delivery agent, so normally it's the municipality. It's available in—I can rhyme off the municipalities, if that would help: Algoma, Brantford, Chatham-Kent, Dufferin, London, Muskoka, Ottawa, Peel, Parry Sound, Prince Edward-Lennox and Addington, Peterborough, Sault Ste. Marie, Stratford, Thunder Bay and Wellington. It is also available in three First Nations: Nawash, Wikwemikong and M'Chigeeng.

M^{me} France Gélinas: How were those chosen?

Mr. David Carter-Whitney: Initially they were communities that wanted to—when we initially rolled it out, we sought willing partners, candidly, certain municipalities and delivery agents who wanted to proceed.

M^{me} France Gélinas: Okay. What does it look like? Every Ontario Works office tries to find employment, and their caseload has lots of people with substance abuse on it. What's the difference?

Mr. David Carter-Whitney: What the ASI does is that it's essentially a more intensive case management. We work closely with the Ministry of Health to try and help promote access to detox and addiction services programs that are funded through the Ministry of Health. It's a more intensive case management, candidly, that helps individuals access housing while they're treating the program, and helps individuals develop a plan of action around their addiction. It helps to make sure that

they actually are attending and encourages and supports. As I say, it's a higher level of intervention than regular clients receive, quite honestly.

The Chair (Mr. Kevin Daniel Flynn): Thank you, David, for that answer. Let's go on to the government side.

Ms. Helena Jaczek: Thank you so much. Your anecdotal stories are useful in that they show some gaps, successes and failures.

My first point is, do you evaluate your programs? You've obviously sort of tracked people and seen where success lies and so on. Is there something in terms of what works so that you can give us positive results on some of our programs and just link that with one of your recommendations, which is to adopt a person-centred approach to mental health and addictions? In saying that, is that based on evidence of a program where you've had some intensive case management? If you could give me an example: Who's been doing the case management? Anything that you can elaborate on those lines would be helpful.

Ms. Lucille Roch: We're currently evaluating the addictions services initiative, the ASI program. Early indications are that it is successful in terms of getting people the treatment they need and then helping people get access to employment or housing. The evaluation is not complete at this point. We just have preliminary findings. But it is—

Ms. Helena Jaczek: Does that involve the sort of intensive case management component?

Ms. Lucille Roch: Exactly, yes. I don't like to use the word "handholding," but it's a lot of working really closely with individuals, making sure that they have access, they get to their appointments, they follow their programs. There's a lot of encouragement. It's very intense.

Ms. Helena Jaczek: Who does the case management? Is this a social worker?

Mr. David Carter-Whitney: Yes, I believe they are; they're trained social workers, is my understanding. We have to approve sites that are—municipalities that were a part had to put forward a plan describing how it was delivered and who would be delivering it, and then the director of Ontario Works authorizes the delivery of the program. So I believe there are requirements around criteria for staff.

Ms. Helena Jaczek: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you, David. A final, short question from Liz and then on to the PCs.

Mrs. Liz Sandals: I was just looking at the case history you've given of Brian, who's a man with a dual diagnosis of developmental disability and mental illness—he's attacked his family, so violence is involved—and who needs placement in some sort of specialized home. The local developmental services residential system can't handle the mental health/violence issues, so he's still in forensic corrections.

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This would be maybe partly a question for you and partly a question for MCSCS, but do we have any idea how many people we've got in that sort of suspended dual diagnosis with violence who can't get residential placement in their home community, or any community, because of the violence issues?

Ms. Lucille Roch: I don't think we have a number for you. There's a planning process at the local level, where some of these situations are brought to a committee of service providers and there's some discussion about who can provide what. In many of these cases, there's a lot of toing and froing between health and ourselves, and—

Mrs. Liz Sandals: And constituency offices.

Ms. Lucille Roch: Yes. We do have an MOU with health on trying to resolve these situations, and in some cases, we're more successful than in other situations, but I don't think we have a—

The Chair (Mr. Kevin Daniel Flynn): Thank you—

Mr. David Carter-Whitney: I'd just also say that the answer isn't always going back to a group home, that some of these individuals—the vast majority of people with developmental disabilities don't live in group homes; they live in family situations or more independently, and some of these people, with the right supports, can move back to that situation. So one of the things we fund is trying to help people move back in to a more independent life and not straight into a group home or some form of quasi-incarceration, if we can avoid that.

The Chair (Mr. Kevin Daniel Flynn): Thank you, David. We'll move on to either Christine or Sylvia.

Mrs. Christine Elliott: I was really struck by the statistic that over 50% of people receiving ODSP benefits have mental health issues. I was particularly struck by John's story that indicates the problems he's having with keeping employment and receiving assistance.

Are there any programs out there that you know of, other than your addiction program, that really work to educate employers about how to work with clients who have mental health and/or addictions problems, and do you think that would be a benefit if there aren't any?

Mr. David Carter-Whitney: Yes. We have a couple of approaches. One is, there was an employment strategy introduced for ODSP in 2006 which took our employment supports to what I'll call an outcomes-based approach. We stopped funding on activities and said that we'll fund it by placement and success, which meant that they could do whatever they wanted. They could go into the workplace, they could continue to—and, in fact, they're incented and paid if the individual stays employed after coming into ODSP. Many of those individuals they help are people who have episodic mental health issues and such. That's one set of things we've done to try to make the programs more flexible and, candidly, to make it easier for the response to be tailored to the individual.

Ms. Lucille Roch: In terms of programs, outreach to employers, the only one I'm aware of is really out of CAMH. I think they do some of that. We in the ministry

are trying to educate ourselves in terms of working with employees who have mental health issues.

Mr. David Carter-Whitney: Although we do also have an initiative with Canadian Manufacturers and Exporters. It's more for people with disabilities more generally, and it seeks to have 10% of their new hires be persons with disabilities. That's the target, so we're working with them around educating employers. But that's not specific to mental health; it's for persons with disabilities.

Mrs. Christine Elliott: Thank you.

The Chair (Mr. Kevin Daniel Flynn): One more short question and then we're done.

Ms. Sylvia Jones: The domiciliary hostels: How many spaces would there be across Ontario for that? Can you provide the committee with a list of where those are?

Ms. Lucille Roch: We can provide you with the information, but I don't think we have it with us.

Ms. Sylvia Jones: Okay.

The Chair (Mr. Kevin Daniel Flynn): Thank you. That was a short answer. Thank you very much for attending today. Your presence was our pleasure.

Ms. Lucille Roch: Thank you.

MINISTRY OF COMMUNITY SAFETY AND CORRECTIONAL SERVICES

The Chair (Mr. Kevin Daniel Flynn): Our next speakers today are from the Ministry of Community Safety and Correctional Services. If you would come forward. Make yourselves comfortable. You've got 30 minutes, like everybody else has today. We'd ask that you leave some time at the end for any questions. We'd also ask that when you speak, you identify yourself for Hansard. Other than that, the floor is all yours. Thanks for coming.

Ms. Laurie LeBlanc: I'll start by introducing myself. My name is Laurie LeBlanc. I'm the assistant deputy minister of policy and strategic planning for the Ministry of Community Safety and Correctional Services. That's a real mouthful.

I have with me today some of the operational experts from the ministry, and I know that they will be very pleased to answer any of your more specific questions. I am joined by, on my left, Judy Alton, who is a sergeant with the OPP. She's the provincial coordinator of vulnerable persons in the crime prevention section. She is our OPP expert. I have Loretta Eley to my right. She is the director of the strategic and operational initiatives branch on the corrections side of the ministry. As well, I've got Stephen Waldie, who is the director of the external relations branch. He deals a lot with our municipal police services. So that's the lineup for today.

I have a fairly concise slide deck. I'm going to take you through it relatively quickly. I'd like to leave about 15 minutes for questions and answers because I'm sure you'll want to get into that.

On slide 2, what I want to do, and we've got in the deck here, is just provide you with an overview of the

Ministry of Community Safety and Correctional Services and what some of our programs, policies and initiatives are that are aimed at Ontarians whose lives are impacted by mental health and addiction issues. I'll talk a little bit about some of the typical interactions that those individuals have with the people who work in our ministry and also give some examples of training and other initiatives that we have in the ministry.

Just for a bit of background, for those of you who might not be completely aware of what our ministry does, our mandate is to serve all of Ontario's diverse communities to keep our province safe. We are the largest ministry in the Ontario public service. We have about 17,000 staff. We are for sure the largest, and one of, I guess, the few direct service providers in the Ontario government. We provide a very large range of services, including front-line policing through the OPP. We also establish policing and private security standards. We provide oversight services to police. We provide a variety of other services on the community safety side: the Office of the Chief Coroner, for example. Through the fire marshal's office, we also provide fire investigation and prevention, as well as education services. We also have Emergency Management Ontario in our ministry. So it's a wide range of services.

Of course I cannot forget half of our ministry, which is the corrections side that provides the supervision and also attempts to positively influence the rehabilitation of adult offenders, both in institutions and out in the community through probation and parole offices.

We work really closely with the Ministry of the Attorney General and the Ministry of Children and Youth Services, in particular, as well as the Ministry of Health and Long-Term Care and other ministries.

I just want to note, before I go on to the next page, that I know this committee has heard from other delegations about youth offenders. That is the responsibility of the Ministry of Children and Youth Services. On the policing side, we deal with everyone. On the corrections side, we just deal with adults. I just wanted to make that clear before we moved on.

On page 4, there are a few facts. I can tell you that understanding the nature and the extent of involvement of persons with mental health and addiction issues, in terms of the impact on the criminal justice system, as well as the impact of the system on the individual, is a real priority for our ministry. We know, and the Ontario mental health association has indicated, that individuals with mental disorders are more vulnerable to detection and arrest for nuisance offences, whether that's trespassing or disorderly conduct, and they're more likely to be remanded into custody. So we have been having discussions with our colleagues across the country. This is not just a problem in Ontario, of course.

On the federal-provincial-territorial side, we've been working on the corrections and on the policing side to gain a better understanding of the issues. We know that just over 50% of all Canadian offenders report that substance use or abuse was directly related to one or more of

the offences on their present conviction. I think you've been told, as well, that people who suffer from mental health issues also often suffer from drug or other substance abuse problems. Quite frankly, that creates some fairly significant challenges in terms of managing our institutions and our supervision of individuals in the community.

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Page 5: I just want to point out that in terms of our ministry, mental health and addiction issues really cross all services that we provide. On the police side, the law enforcement officers are often the first responders, so they're the ones who have the first interaction with people who have mental health or addiction issues. We do note in the slide deck here that contact between the police and these individuals has been increasing over years. That also translates into a higher percentage, an increasing percentage, of individuals who have been put into our institutions in remand, who have what we call mental health alerts on their record when they're admitted. We also indicate here that about two thirds of the people admitted to our institutions have had alcohol or drug problems, and many of them continue to have those problems.

So you can see that we're an active, interested partner with our other justice ministries, the Ministry of Health and Long-Term Care and others, to really look for collaborative solutions, to try to do our best to find better solutions to deal with individuals with mental health and addiction problems in our institutions.

I want to take just a few minutes to talk about police. On page 6, I list the authorities that the police have under the legislation. I'm not going to take you through that now. You can read that at your leisure.

Our ministry, through the OPP, I want to specifically note, with about 5,000 front-line officers who on a daily basis can and do interact with individuals, many of whom do have mental health and addiction issues—we have that experience. Also, through legislation, guidelines and ongoing collaborative work, we have a close relationship with the municipal police services.

I will note that on this slide we talk about diversion in the areas of mental health and substance use and abuse. I understand that when he was here, my colleague from the Attorney General spoke about diversion after charges have been laid and some of the strategies that they have there. Of course, I think we should note that on the police side, they have the discretion to lay charges or to divert some of those individuals to other community facilities or other accommodations or treatment programs. So the police can and do make those judgments on a daily basis.

On the policing side, officers play an important role. As I said, they're often the first responder. The other side to this, of course, is that that's an increasing responsibility and some pressures in terms of resources and the workload of our officers.

How do we help to ensure that our police have the proper tools? Obviously, if they're first responders, we need to make sure that they have the tools at their disposal.

On page 7, we talk about training. We do this in a couple of ways. The ministry has developed some guidelines that go out to municipal police services to help them develop policies that work locally for response to persons who are, as we say here, "emotionally disturbed or have a mental illness or a developmental disability"—that's the name of the guideline. The training begins early for police officers. In the Ontario Police College, there are about eight hours, as part of basic training, that are dedicated to responding to individuals with mental health or addiction issues. There is also refresher training, specialized training, through the course of a police officer's career.

The police college has also made quite a few connections with community organizations. They provide officers with a pocket guide, to assist them when they're on the spot in terms of recognizing basic symptoms of mental disorders and appropriate response strategies.

As well, I know that the OPP has some extra training that they have provided for officers and some innovative modules that they've created. I'm sure Judy can speak to that later, if you're interested.

The last piece on this slide is on the community safety side. The Office of the Fire Marshal has been involved with CAMH in providing assessment, treatment and fire safety to young fire-starters and their families. We know it starts early. The Office of the Chief Coroner, as well, has a database which tracks, through their death investigations, the causes of death including alcohol-, drug- and gambling-related deaths.

Just a few minutes to talk about the corrections programs on page 8: When somebody is brought in to one of our institutions, there is an assessment that's done on intake. Loretta is our expert, and she can answer any questions about that, but I did want to note that there is a health assessment that's done for those individuals and that includes an assessment of mental health issues. On the institutional side there are a number of elements that we've listed here. We have professionals who are in our institutions or available to our institutions—psychiatrists, psychologists, social workers, doctors, nurses and others—and they do provide rehab programs to sentenced offenders. I did want to just highlight that there is a challenge because the number of sentenced offenders in our institutions is much lower than those on remand, and it is a challenge in terms of offering programs to people who are there on a remand basis and not in a sentenced capacity.

The other note we make here is that community organizations will often come in to our institutions and offer programs, whether it's Alcoholics Anonymous, Gamblers Anonymous or Narcotics Anonymous, some of the examples we've listed here. We have a few specialized facilities which are particularly helpful for assessment and treatment capacity, and that's, again, for sentenced offenders. Also, on the community side, through our probation and parole offices, as part of the discharge planning for inmates, there is an assessment done, and often referrals are made and work is done with

the Ministry of Health and Long-Term Care in terms of referrals to community organizations.

On page 9, just a reminder of the collaboration we're trying to have with our other ministries, and you've heard about this from our colleagues already. We are very involved in the development of a government-wide mental health and addictions strategic plan, so I guess that's at the higher level. We've also been working on the ground very collaboratively with the Ministry of the Attorney General as well as the Ministry of Health and Long-Term Care and others in terms of mental health assessments, and we're very involved in the human services and justice coordinating committees. I know that the representative from MAG mentioned those as well. These committees establish more coordinated resources and services, in terms of planning for individuals who are in conflict with the law. We're involved in the policing and the corrections side, both at those local committees and the regional committees, so we're quite committed to that.

Lastly, in terms of next steps, you may have heard us talk about being "tough on crime and the causes of crime." I'm sure some of you in the room have heard that phrase before. For us, what that means is it's really important to strike the balance between prevention, deterrence and rehabilitation, that those are important aspects when we're looking at the people in our care. As part of our strategic plan in the ministry, we've also identified that as a key initiative an attempt to work more effectively with specialized and marginalized groups, and people with mental health issues and addictions are part of that group for sure.

I guess the last point on this page is really to say that we're very committed and we're pleased that there are initiatives like this going on, because I think the more we can do to find better, more efficient ways to deal with individuals with mental health and addiction issues in the appropriate way is better for the individual and, for sure, it's better for our institutions and other parts of the ministry.

So that's it for my slide deck, and I've left enough time for questions.

The Chair (Mr. Kevin Daniel Flynn): Thank you. You've left us all sorts of time, so I'm going to steal a little bit of that time right now from the Chair. Can you just expand on what you mean? Not all of us are lawyers; in fact, I think only Christine is. What's the difference between a remand and a sentence as far as somebody and the service they receive?

Ms. Loretta Eley: A remanded person is someone who's still appearing before the courts and has not yet either been convicted and/or sentenced. They could be convicted but not yet sentenced, or they could have not been convicted yet before the courts. They're still awaiting trial—

The Chair (Mr. Kevin Daniel Flynn): Okay. So how does that impact on the treatment they get?

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Ms. Loretta Eley: It impacts quite seriously because what happens is about 63% of our population right now

is on remand, so they're still awaiting, if you will, their fate. They're uncertain, unsure and still attending court, so they're in and out of the institution quite a bit. Most of them elect to have weekly remands, and if they're not being done through video port, it means that at least one day a week they're gone.

The second piece is that the median, in other words, 50% of the remanded population—we already know it's more than half—leaves in less than eight days. So by the time you get them in, they make their first appearance at court, and then they stay—they're more focused on getting out, so getting their bail set, meeting the conditions of bail and trying to get out, and 50% of them leave within eight days.

The Chair (Mr. Kevin Daniel Flynn): Thank you. Final question, for myself, anyway. There's a school of thought out there that says that early intervention should keep people out of the justice system entirely. What does it cost to keep a person incarcerated in Ontario on an annual basis these days, just approximately?

Ms. Loretta Eley: I couldn't tell you annually. Our average per diem is approximately \$160 per day throughout the system.

The Chair (Mr. Kevin Daniel Flynn): So that's all costs in?

Ms. Loretta Eley: That's all costs in—everything.

The Chair (Mr. Kevin Daniel Flynn): Okay. Thank you. Who's going to ask questions from the government? First Jeff and then Liz.

Mr. Jeff Leal: Thanks very much, Kevin. Through to Ms. LeBlanc: Thank you so much for your comprehensive presentation.

I know in my own community, these days the substance of choice seems to be a prescription drug, OxyContin. I'm interested in knowing if it's getting to people who are in our corrections system. I notice we have \$50 million to do some targeted work. It's a growing concern, particularly with high school students, whether we can stem the flow and what we're doing to try to target that group. It's a very troubling situation that leads to other ramifications down the road that are perhaps much more serious.

Ms. Judy Alton: I don't have a specific answer, if we're looking at that particular drug—

Mr. Jeff Leal: Could you get back to the committee?

Ms. Judy Alton: Yes, we can.

Mr. Jeff Leal: I appreciate that. Thank you so much.

The Chair (Mr. Kevin Daniel Flynn): Liz?

Mrs. Liz Sandals: I was just going to ask a little bit more about the remand versus sentenced issues. You've got this large population that's on remand, much of which is not going to be there for long, and another portion of it which is unco-operative. And because they haven't been convicted, you can't force them to participate. There's probably also, though, part of the remand population that's just undergoing a very long, complicated trial and clearly has mental health issues. Can they voluntarily access service if they wish? I understand that most of your remand population is either too unstable or

too contrary to seek service, but in those cases, where they are seeking service, can you provide it while they're on remand?

Ms. Loretta Eley: Yes. We have a couple of options. When I talk about programs we have, our programs are difficult. By the time we assess someone and try to put them in a program, which perhaps runs once a week, you can see the logistics of that don't work too well. But for our offenders who are mentally ill, they're seen by the psychiatrist; they can still see that person.

We have discharge planners who are part of the Ministry of Health who see all of our people in custody who have been diagnosed with a mental illness. They see those people with a view to, "What are you going to do when you get out? How are you going to manage?" They also will often see a nurse on an ongoing basis, and, in not all of our centres, but in five of them, we have a treatment program. That's not limited to remand or sentenced. If the need is there and they're in one of those facilities or can be transferred to it, then they can go to it.

The one exception is the Ontario correctional institute in Brockville, where we have the Brockville treatment centre that is run by the Royal Ottawa Hospital. We don't generally take remanded people, but we have had a few who were quite disturbed.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Loretta.

Mrs. Liz Sandals: Can I—just a quick yes or no?

The Chair (Mr. Kevin Daniel Flynn): Very briefly.

Mrs. Liz Sandals: If you've got somebody who is a likely candidate for Penetang, can you start treatment while they're still on remand?

Ms. Loretta Eley: Absolutely. We can also send them to a mental health facility.

Mrs. Liz Sandals: Okay.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Loretta. Sylvia?

Ms. Sylvia Jones: I guess this would be to Sergeant Alton. I don't know all the details, but I understand there is a program, probably through metro Toronto police, where they have nurses specially trained in mental health available for front-line officers. Are you familiar with that program, and if you are, are there other jurisdictions that offer that to their police services?

Ms. Judy Alton: Yes. There's the COAST program in Hamilton, and they do crisis intervention training. Again, they have a psychiatric nurse available to them.

I'm not aware of the metro program. Maybe my colleague can answer that question.

Mr. Stephen Waldie: The metro program is actually a ride-along program, so the mental health worker actually rides along with a designated police officer and is available to assist in those calls.

Ms. Judy Alton: I believe Windsor just started that program as well.

Ms. Sylvia Jones: And it's called COAST?

Ms. Judy Alton: The COAST program is strictly for Hamilton.

Ms. Sylvia Jones: So they're all sort of customized?

Ms. Judy Alton: They're all customized for their own areas.

The Chair (Mr. Kevin Daniel Flynn): Christine?

Mrs. Christine Elliott: I would add that Durham regional also has a ride-along program with a nurse who has been seconded from the Whitby Mental Health Centre, and it's working very successfully. It's very effective.

Two quick questions: One is with respect to the discharge planners when they're working to locate people once they're released back into the community. Are they doing all right, in terms of their placements? We keep hearing about the lack of psychiatrists in many parts of the province. Are they having any increased difficulties, or are they finding that things are pretty easy to do?

Ms. Loretta Eley: With people who are discharged from the facility, there's the pre-discharge period where they work with them and the post-discharge period, which is up to three months, and then they're supposed to be linked with straight community resources. They're just starting the evaluation of that work now, because it has only been about a year that we've had the discharge planners throughout our institutions.

Mrs. Christine Elliott: Just one other quick question: Where do you need help the most? Where do you think your programs could use assistance, or what's the greatest stress on your system right now, in terms of mental health and addiction issues?

Ms. Loretta Eley: I think that for corrections, one of the largest issues is that people see people as either criminals or sick persons, and it's sometimes difficult getting past that mindset, in terms of services.

Our other issue is trying to get the foot in the door to get services for our people, because they aren't always—I don't know how to say this—the most pleasant, and they're sometimes very difficult, high-needs people; they aren't all, but some of them have gone untreated for a long time and they're a real challenge.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Christine.

Ms. Laurie LeBlanc: I think, as well, Sergeant Alton would like to—

The Chair (Mr. Kevin Daniel Flynn): Very briefly.

Ms. Judy Alton: From the policing perspective, I think our biggest challenge when we bring an individual in to the hospital to be assessed is the wait time for the police officers at the hospital. They're waiting anywhere from four—and I'm hearing up north up to eight—hours with a patient before a doctor will even come in and give an assessment. I think that is one of the biggest challenges for us.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Sergeant. France?

M^{me} France Gélinas: You've mentioned that you do an assessment of all the inmates before they go to a correctional institution. Can you talk to me about whether there is mandatory health care staffing in all the jails? Do they include specialists in mental health—a mental health

nurse or a psychiatric nurse? And what's the ratio of health professionals to inmates, if such a thing exists?

Ms. Loretta Eley: In all of our facilities there is a health assessment and it's done by a registered nurse. All of our nurses have expertise in mental health. They may not be technically a psychiatric nurse, but they all have that background. So there's a health assessment and a mental health assessment, and then a referral to the psychiatrist if there is a need to do so.

In terms of the ratio, there is a ratio—I'm sorry, I'll have to get back to you with what it is. I don't recall it offhand.

M^{me} France Gélinas: So after the assessment, somebody is tagged—I forget what you call it, but they have a mental illness; everybody knows. There may even be a diagnosis. Will there then be treatment? If somebody comes in with a wound, whether he's remanded or sentenced, they will dress it. If somebody comes in with an acute mental illness, will there be a nurse there to look after them?

Ms. Loretta Eley: I'm sorry, I misunderstood. Yes, there will be. What happens is that in most cases, in most of our facilities, we have a designated area that may not provide specialized programming, but it's called a special needs unit, where we put people together who have issues, usually mental health but occasionally serious physical health issues, and those people are seen by the physician and the nurse regularly. As well, our correctional staff receive specialized training in dealing with mentally ill offenders.

M^{me} France Gélinas: Do you see a trend toward more people with mental health illness or issues going into correctional facilities, or are some of the programs working and you're seeing a downward trend? I visited a jail—I used to work with the homeless—and I was amazed to see how many of my clients were in there. So I'm thinking, is it the same thing everywhere?

Ms. Loretta Eley: With the closures of the mental health facilities, we have experienced an upswing in the number of people who are not caught in a social safety net. I think that may be changing as a lot of these programs have been developed. They're working interministerially, so that there is a strategy for trying to deal with these people before they come into jails and correctional centres. In terms of—

M^{me} France Gélinas: Would you say that there is a downward trend or that you're hoping it's about to happen? Or is it not happening?

Ms. Loretta Eley: I think what we're discovering now—we have some research being done under the auspices of health that says that about 36% of our clients who are in custody may not have a major mental illness, but if they were to go and be assessed at, say, Queen Street or any of the Ministry of Health facilities, they would be deemed to be eligible for those services. So somewhere on the continuum they're there. I think that's an increase over years ago, but what I'm hoping is that it's a decrease over a few years ago. But we don't know that yet.

The Chair (Mr. Kevin Daniel Flynn): Thank you for coming today. Your input was appreciated.

MINISTRY OF CITIZENSHIP AND IMMIGRATION

The Chair (Mr. Kevin Daniel Flynn): Our final presentation today comes from the Ministry of Citizenship and Immigration. We've got Minister Chan with us and his staff. If you'd come forward, Minister Chan, and make yourself comfortable. Thank you for coming today. Like all other delegations, you have 30 minutes. If you could leave some time at the end for some questions, that would be appreciated by the committee. If each speaker would state their name for Hansard, that would be appreciated. The floor is all yours.

Hon. Michael Chan: I think my time is 29 minutes. Good afternoon, and good early evening, Chair, committee members, colleagues, ladies and gentlemen. It's an honour for me to speak to you today. With me today is ADM Katherine Hewson from my ministry. I will be having opening remarks and Katherine will go through a few slides with you. After that, we can answer a few questions, if we do not exceed the 29 minutes.

First of all, I would like to note my full support for this work on mental health and addiction. I applaud Minister Caplan for his commitment to this issue and for bringing it into the spotlight.

Mental health and addictions are difficult issues, issues that many are uncomfortable talking about. Yet we need to examine, as a province, how we support those who are impacted. Almost all of us have been touched at some point in our life by mental health or addiction, whether by direct experience ourselves or through our loved ones. You have already heard that one in five people will experience a mental health or substance abuse problem in their lifetime, so developing a comprehensive provincial strategy on mental health and addiction is critical.

I commend you for taking a holistic approach to this issue. I note your early discussions quickly focused on the need to look not only at the health sector, but also at sectors such as housing, justice and education, recognizing that solutions to mental health and addiction challenges must be multi-layered. In addition, your mandate identifies some specific groups to look at—groups such as seniors, youth and ethnic minorities—that may face very specific challenges. The points I would like the committee to consider relate to the sometimes unique mental health needs and experience of newcomers, and it's important to keep in mind that much of our future population and economic growth will come from immigration.

As the Minister of Citizenship and Immigration, I am keenly aware of the many challenges newcomers to Ontario face. Some newcomers, such as many government-sponsored refugees, arrive having escaped horrific conditions like war, famine and displacement, and clearly exhibit signs of post-traumatic stress disorder. Others

may arrive with great hopes and expectations, yet face isolation and cultural shock. Uprooting oneself to move to another country, often leaving behind family and friends, requires courage. It can also be traumatic, resulting in the loss of support networks, one's place in society and meaningful employment.

As one of your previous presenters from Parents for Children's Mental Health notes, loneliness and not being connected can be an impediment to receiving appropriate care for mental health issues. For immigrants without a support network or family and friends, loneliness and not being connected are often a sad reality, particularly for those without employment. Isolation can both trigger addictions and mental health issues and prevent newcomers from accessing services to help them.

Other issues unique to newcomers may include cultural barriers to recognizing mental health issues and the stigma associated with seeking treatment. People from some cultures may not be able to describe depression or anxiety in terms familiar to North Americans. Admitting to feeling overwhelmed may be seen as a sign of personal weakness. As well, language itself can be a barrier for newcomers. They may not be able to effectively communicate their mental health concerns to a doctor or to another service provider who might take appropriate actions, and timely interpreter services are not always available.

Unfortunately, many immigrants from a wide area of source countries still report facing discrimination and harassment in various aspects of their lives. They may also face stresses such as unemployment, underemployment and lack of credential recognition. The current economic situation may compound this. While this affects all Ontarians, research has shown that newcomers are particularly vulnerable to economic downturns. There are also stresses on available services when many of our residents need help in dealing with difficult issues beyond their control, and in some instances, costs can be a barrier to accessing services.

My goal as Minister of Citizenship and Immigration is to try to help ensure that our newcomers have the opportunity to participate fully in the economic, social and cultural life of this province. Like other Ontarians, they cannot do so if they have unaddressed mental health or addiction issues.

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There are many challenges that we need to be aware of when speaking about newcomers and mental issues: post-traumatic stress disorder, cultural taboos, economic stresses, language barriers and isolation, among those I have briefly touched upon. Having said that, I must acknowledge that there has been some good work already done in this field. Settlement agencies and other committed organizations are often the first point of contact for newcomers. Many of these agencies have trained staff who are well positioned to provide referrals to mental health practitioners, so a lot of these necessary linkages are in place. To ensure access, service providers must be sensitive to the unique mental health challenges newcomers face.

Another task is to ensure that newcomers know how and where to access services for their mental health and addiction needs and know what supports are available. In the coming weeks my ministry will be initiating discussions with some of the stakeholders on these issues. I am committed to supporting your work, and we will be happy to share the results of our discussion with you.

Again, thank you for the opportunity to talk to you. Now my ADM, Katherine, will go over the slides with you and afterwards we can answer a few questions.

Ms. Katherine Hewson: Thank you, Minister. Katherine Hewson; I'm the Assistant Deputy Minister in the Citizenship and Immigration Division of the Ontario Ministry of Citizenship and Immigration. I'll try to go through these slides fairly quickly in order to leave committee members time to ask questions.

In the presentation I'd like to just provide some context and background on immigration in Ontario, identify some of the mental health and addiction issues facing immigrants and the kinds of circumstances that might lead to that, identify some challenges to obtaining treatment, and also mention some best practices and potential next steps for working in this area.

On slide 3 you'll see some of the factors that can increase the incidence of the mental health problems and addictions. We know that poverty, unemployment, discrimination, low education, literacy issues and lack of social supports can all lead to more mental illness and addiction issues. The challenges that newcomers face can make them particularly vulnerable to these problems.

To show you a little bit around the numbers of immigrants coming to Ontario and some of the top source countries of immigrants, you can see on slide 4 that in 2007 we received about 111,000 immigrants to Ontario. They come from about 250 countries, and you can see on the chart the top source countries.

Ontario and Canada share the responsibility for providing integration language services and settlement services to newcomers. Ontario spends in the neighbourhood of about \$188 million a year on these kinds of services. The federal government is a larger funder and is funding approximately \$407 million a year.

On slide 5 you can see some information, and if you just take those numbers and apply what we know around the incidence of mental illness and addiction, if we assume that one in five Ontarians—and this would apply to newcomers as well—will experience mental health challenges in their lifetime, that means there would be 22,000 newcomers a year who would be facing mental health challenges. Similarly, if you take the 5% of addictions for the general population and just apply that to newcomers, then you're dealing with about 11,000 newcomers. We don't have good information on the incidence of newcomers and that is certainly a gap.

On page 6, you can see the kinds of issues that newcomers face just as a regular part of the immigration process. They can be away from family and friends, they can be away from a familiar culture, and learning to settle and making the decisions that are necessary to settle

effectively in Ontario can be stressful. Securing a place to live, finding social services, finding health services and learning to speak the language can be very considerable; getting their children into proper schools and understanding the school system. Finally, a big issue is gaining Canadian work experience or finding work that is appropriate for their experience, education and expectations.

What we also find is that many newcomers have less than successful outcomes, especially early in their integration process, and this can contribute to mental health and addiction problems; for example, being unemployed or working in low-skill or part-time jobs; having difficulty in speaking English or French; being unable to work in their field because qualifications that they have from their home country are not recognized in Ontario; experiencing discrimination and social exclusion; experiencing a loss in social status; and having left behind the kinds of supports that we all have from family and friends.

Refugees, we know, are at even higher risk than general immigrant populations. Out of the 111,000 newcomers who arrived in Ontario in 2007, 14% were refugees. We know that especially government-sponsored refugees, but all refugees, may have experienced severe trauma, and they have distinct mental health needs. There have been some studies that have tried to assess this. There was a study of about 7,000 global refugees moving to western countries. Of those, 9% were diagnosed with post-traumatic stress disorders, 11% of the children had post-traumatic stress disorders, and 4% to 6% of all that population had significant depression.

In addition to the kinds of experiences that can add to the stresses, the fact of being an immigrant can also create barriers to accessing the kinds of services that we have in Ontario. People may not be aware of the services that exist; there may be limited services that are culturally appropriate outside of large urban areas; people will have difficulties expressing their issues in a language that is not their native language; and there are cultural and interpretation difficulties.

Not all cultures look at mental illness or would even describe mental illness in the same terms as we in Canada or in North America would, so this creates some issues as well. As you know, there is a stigma generally that's attached to mental illness, and this can be even more so in some newcomer communities.

Finally, because sometimes immigrants are in precarious employment, they may not have employee benefits that would support payment for some of the other services.

In addition to the provincial action that you're leading and contributing to, there is also, you may well be aware, some national action happening, and our ministry has been invited to participate in some of that. The Mental Health Commission of Canada has developed some recommendations and will be consulting on these recommendations on how to improve the mental health of Canadians from ethnocultural and newcomer communities. They have identified four pillars, which are co-

ordination, information, community engagement, and more and more appropriate services.

I just want to spend a moment on some of the Ontario resources to assist newcomers in making the transition successfully into life in Ontario and then what we know of some specialized services on mental health. I won't go into this in detail, but the Ministry of Citizenship and Immigration provides general services—settlement programs. So we fund community partners to provide information and referrals for newcomers, we provide language training for adults, and we also provide more specialized—what we call bridge training programs that help people who have professional accreditation and experience make that bridge into Ontario so that they can be licensed professionals and get jobs that are appropriate to their experience and education.

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These programs do help, when they are successful, to reduce the stresses of unsuccessful integration. They can get people into good jobs, reduce their lack of status—and of course just financial ability.

We also, through our programs, provide information generally to newcomers on a variety of issues, including the availability of mental health supports. The newcomer settlement program does that by providing funding to settlement workers and community agencies. We have a portal, www.OntarioImmigration.ca, which provides a wide range of information. We also have a specialized service for victims of domestic violence called language interpreter services, and this is interpretation that can support a victim of domestic violence who doesn't speak English through a number of programs that they need in order to get help. It can be courts, but it can also be mental health issues.

You can see that on page 13 we've tried to just show the range of where services can be provided to newcomers. They can have some counselling and information and referral from settlement agencies; multicultural agencies also can refer. Community health centres quite often have a specific focus on newcomer populations, and hospitals as well. There are some good programs, as I'm just going to mention.

For example, the Canadian Centre for Victims of Torture is renowned for providing counselling, support groups and crisis intervention for people who have experienced torture—many refugees—and we fund them through the newcomer settlement program; a small amount of funding, but funding specifically to help.

I think, just in the interest of time, I'll go on. The other issue that agencies that we work with are addressing is trying to help general mental health service providers understand and be more responsive to the needs of cultural communities and newcomer groups. For example, Across Boundaries, an ethno-racial mental health centre, gives cultural competency training to general providers of mental health services, and that helps them be more specific and appropriate. Similarly, there's an interesting project that the Ontario Council of Agencies Servicing Immigrants has been working on with Hong

Fook Mental Health Association, which is going to be providing training for front-line settlement workers so that they have a better understanding, when their clients present mental health challenges, where the referrals can be made, and they're getting more intensive training on how to identify and provide good referrals.

Having said that, there certainly are ongoing challenges. There is a need for ongoing cultural sensitivity training of staff, the ability to provide services in multiple languages. Sometimes there is a lack of connection between the settlement sector and the mental health services that are available; regional differences in services and resources. There's just a wide variation in the needs of newcomer groups.

As the minister mentioned, we are working with our community partners to consult with them on issues regarding mental health. We've just also been dealing with a number of groups, asking their advice on the next stage of the Canada-Ontario immigration agreement, and it's very clear that mental health is an issue for settlement that needs to be addressed more strongly in the next version of that agreement.

Finally, we would just want to emphasize the importance of maintaining services for immigrants, especially during economic downturns. As the minister said, we know that there can be particular bad effects on immigrants in the job market during an economic downturn, and that's a very significant factor for mental health. We need to improve our ability to integrate newcomers so that we minimize the challenges they have on mental health and addictions.

Collaborating between the Ministry of Health and Long-Term Care and our ministry has been very effective, and we'll continue to do that. We will continue to support the development of cultural competency training for our settlement and mental health service staff.

Another issue that could be addressed is more and better interpreter and language services and more communication and outreach to newcomers. Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much. You've left a little bit of time for questions. Starting with either Christine or Sylvia, you've got about three minutes.

Ms. Sylvia Jones: I'll be fast. You mention on slide 8 that 14% of newcomers who arrive in Ontario arrive as refugees. Knowing that refugees would be at higher risk, are you doing stuff in your ministry to track that 14% to—I guess for lack of a better word—fine-tune your resources to the people who are most likely to need them?

Ms. Katherine Hewson: I would say that some of that happens, perhaps not so much in our ministry. The federal government, in selecting refugees overseas, does provide through their refugee assistance program some special supports to refugees generally for the first year that they're in Canada, and there are some specialized services through settlement agencies and other agencies that support them.

Other than that, we provide settlement funding to agencies to help refugee claimants. Refugee claimants

are not eligible for services from the federal government, so we are filling a need just in that area.

Hon. Michael Chan: I think that's very important to know about the services provided by CIC compared to us. The conventional refugee COIA agreement and CIC will be supporting them, keeping them serviced, but as you know, a lot of refugees just cross the border and become refugee claimants, and they will not be served by the federal program. Our financial resources are quite limited, as you can see from the percentage. So that is the challenge in terms of servicing them based on the financial resources we have, and on the renewal of the COIA agreement, which is coming up, we're trying to talk to CIC about expanding the eligibility of servicing refugees, in whom you've mentioned there seems to be a higher percentage of risk in the mental health issue.

The Chair (Mr. Kevin Daniel Flynn): Thank you. Christine, you've got about a minute.

Mrs. Christine Elliott: I'm just interested in the supports for service providers that you mentioned. Across Boundaries, is that here in Toronto?

Ms. Katherine Hewson: Yes.

Mrs. Christine Elliott: Is that the only one of its kind in the province that you're aware of?

Ms. Katherine Hewson: No. There are other agencies that provide those kinds of services, but they're not widespread. For example, there are some services in Ottawa.

Mrs. Christine Elliott: The other was on the Hong Fook Mental Health Association. Is that also in Toronto, and could we get some additional information regarding that? I'm really interested in the training for front-line workers and, as well, in the cultural competency training.

Ms. Katherine Hewson: We could certainly provide that to the committee.

Mrs. Christine Elliott: Thank you.

The Chair (Mr. Kevin Daniel Flynn): You have about a minute.

Hon. Michael Chan: I was there last weekend attending the volunteer honour function, and this is an organization that serves the Chinese, Vietnamese, Cambodians and Koreans.

They told me, "We are relatively small. We are kind of like struggling on the funding." But they're good people. They've been really trying hard not only to outreach to one group, like one from China, but really outreaching to them, and I think they're doing a good job. There are good people out there, good organizations, but again when we engage in more talk about that, it is really the financial resources.

Also, they mentioned one thing very specifically on these newcomers, the four countries that I mentioned. They wanted me to be there just to raise the awareness because they feel that these people, the community, don't want to talk about it, okay? They wanted me to be there to raise the issue. I was there, and then the newspaper reported, the ethnic newspaper. They encourage the groups to come forward, meaning that there may be more people having this issue, but because of culture or cultural habits, they just don't want to talk about it.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Minister. France?

M^{me} France Gélinas: Thanks for your presentation. I'm on slide 13, where you talked about service delivery. I take it that's for newcomers who already have a mental illness or are struggling with a mental issue.

Ontario is such a rich province. When you look at our newcomers and our immigration, do we have any centres of excellence? Do we have any best practices that we can copy? Who is active in trying to really focus on the mental health needs of the newcomers?

Ms. Katherine Hewson: There are organizations that we have a funding relationship with that I would say excel at this. One would certainly be the Canadian Centre for Victims of Torture. I think they're well known. There are settlement agencies such as OCISO in Ottawa—I'm forgetting what the acronym stands for—that provide counselling services as part of their settlement services. I think the OCASI activity with Hong Fook that I mentioned could be seen as a best practice. There certainly are organizations that we would see as trailblazers or leading in this area.

M^{me} France Gélinas: When you presented slide 5, at the end you used the statistics of one in five and one in 10, and then you did an extrapolation. Do we know, when a newcomer comes, if he or she is in need of mental health support? Would we know that when they come, or do we have to wait until they get in trouble?

Ms. Katherine Hewson: Before they come, people have to pass medical exams as part of the selection process so that they would have some mental assessment at that point, but no, generally we wouldn't know. There's no tracking mechanism. People arrive when they have their visas, and there isn't really a playful way of knowing that.

Hon. Michael Chan: And by the way, the tracking is the federal government. The health and also security would be done by the federal government.

But one statistic we have is that when the newcomers are here longer, the percentage of the mental health issue seems to be rising. When they come here, they seem to be okay. But when they're here one, two, three or four years, it seems to be that they are not as okay as before. That's the trend that we've started to notice.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Minister. A final question, Jeff.

Mr. Jeff Leal: Thank you, Minister Chan, for your presentation. I just want to ask the ADM a question: In any given year, how many foreign-trained psychiatrists would be arriving in Ontario? How quickly are we putting these foreign-trained psychiatrists through the accreditation process so they can start practising? We all know there's a Canada-wide shortage of psychiatrists.

Ms. Katherine Hewson: I don't have that information, Mr. Leal, but I think we can provide that to you.

Mr. Jeff Leal: Could you get back to the committee clerk with that? I'd appreciate getting that information from you.

Ms. Katherine Hewson: Sure.

Mr. Jeff Leal: Thank you so much.

The Chair (Mr. Kevin Daniel Flynn): Thank you for being here today. Sylvia, did you have one more question?

Ms. Sylvia Jones: Not related to the presenters, but I did have one before we—

The Chair (Mr. Kevin Daniel Flynn): Okay. Let's allow our guests to leave first. Thank you very much for being here today. It's appreciated.

Hon. Michael Chan: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Sylvia?

Ms. Sylvia Jones: Mr. Leal reminded me that we have asked presenters to bring back stuff over the course of the last number of weeks. If that has not arrived—and I certainly haven't received it—can we follow up?

The Chair (Mr. Kevin Daniel Flynn): Yes. I'm sure it's all being tracked. I think at some point in the near future, we'll have heard from all the ministries that are presenting. I would hope all the information would start to come in by that date.

Ms. Sylvia Jones: Okay. So you'll do a letter for stuff that hasn't come in?

The Chair (Mr. Kevin Daniel Flynn): Anything that comes in to the committee I will circulate immediately through Susan.

Ms. Sylvia Jones: No, I'm sorry—you'll do a letter to the ministries that have not brought back the requested information?

The Chair (Mr. Kevin Daniel Flynn): If it looks like it's necessary, I will, yes.

Any other questions? If not, thank you for your attendance today. We're adjourned.

The committee adjourned at 1802.

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MH-7

MH-7

ISSN 1918-9613

**Legislative Assembly
of Ontario**

First Session, 39th Parliament

**Assemblée législative
de l'Ontario**

Première session, 39^e législature

**Official Report
of Debates
(Hansard)**

Wednesday 13 May 2009

**Journal
des débats
(Hansard)**

Mercredi 13 mai 2009

**Select Committee on
Mental Health and Addictions**

**Mental health and addictions
strategy**

**Comité spécial de la santé
mentale et des dépendances**

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Telephone 416-325-7400; fax 416-325-7430

Published by the Legislative Assembly of Ontario



Service du Journal des débats et d'interprétation

Salle 500, aile ouest, Édifice du Parlement

111, rue Wellesley ouest, Queen's Park

Toronto ON M7A 1A2

Téléphone, 416-325-7400; télécopieur, 416-325-7430

Publié par l'Assemblée législative de l'Ontario

LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

SELECT COMMITTEE ON
MENTAL HEALTH AND ADDICTIONSCOMITÉ SPÉCIAL DE LA SANTÉ
MENTALE ET DES DÉPENDANCES

Wednesday 13 May 2009

Mercredi 13 mai 2009

The committee met at 1603 in committee room 1.

The Clerk of the Committee (Ms. Susan Sourial): Honourable members, it's my duty to call upon you to elect an Acting Chair. Any nominations?

Mr. Jeff Leal: I want to nominate—

Mrs. Liz Sandals: I nominate Bas. No, I was going to nominate Bas.

Mr. Jeff Leal: I would nominate that Mr. Balkissoon assume the chair.

The Clerk of the Committee (Ms. Susan Sourial): Mr. Leal has nominated Mr. Balkissoon. Any other nominations? No? Mr. Balkissoon.

Mr. Jeff Leal: There we go. We got that resolved.

Mrs. Liz Sandals: There we go.

The Acting Chair (Mr. Bas Balkissoon): Thank you very much. I hope there's a paycheque change coming with this. Okay, Jeff?

MENTAL HEALTH AND ADDICTIONS
STRATEGY

AUDITOR GENERAL OF ONTARIO

The Acting Chair (Mr. Bas Balkissoon): We'll call to order the meeting of the Select Committee on Mental Health and Addictions on Wednesday, May 13, 2009. The first item of business is a deputation by the Auditor General of Ontario. Mr. McCarter, if you would introduce yourself and your guests, you have—is it half an hour?

Mr. Jim McCarter: Half an hour, I understand. I've got some remarks, and I have one overhead. I'll try to keep it to no more than half the time so we do have some time for questions.

The Acting Chair (Mr. Bas Balkissoon): Excellent.

Mr. Jim McCarter: Just to introduce my staff with me for Hansard: I have Rudolph Chiu. Rudolph was a director on two of the three audits that I'm going to be talking about today: community mental health, which is the adult mental health program, and addiction treatment programs. I also have Walter Bordne, who was the director on child and youth health services. I think you've got a copy, hopefully, of the handout in front of you. I tried to put it on one page.

I know Ms. Sandals had mentioned that maybe I should circulate something in advance, and research indicated that copies of our three audit reports had been circulated to you. But just on the off chance, I do have a

two-pager, and I can distribute it if you'd like. It's basically the summary from each of the three reports. It kind of summarizes fairly succinctly what we found in the three audits. If you'd like that, I can distribute it. I don't want to overburden you with paper.

The Acting Chair (Mr. Bas Balkissoon): No, distribute it.

Mrs. Maria Van Bommel: Yes, please.

Mr. Jim McCarter: Okay. I'll just hand this to Susan, and she can distribute it while I'm talking. It just provides a bit more detail on what I'm going to be talking about.

What I'd like to do today really is just briefly give you an overview of some of the key findings from the three audits. We had a bit of a theme in last year's 2008 annual report, where we focused on mental health and addiction treatment services. We also looked at some associated areas, as you know, like correctional institutions. So we had a bit of a mini-focus last year on mental health. I see a couple of members from the Standing Committee on Public Accounts. We have had a couple of hearings of the public accounts committee, and I suspect that some of those recommendations, which will be forthcoming in due course, may be of interest to the committee.

I'll start off by just briefly discussing child and youth mental health services. This is basically mental health services provided to children up to the age of 18. I won't spend too much time on overhead number 3; it gives you a bit of an overview of the program, what the dollars are. The one thing I'd say, though, is that it did become fairly evident to us, sort of the historical basis, that prior to 1970, children's mental health services were very institution-based, in the sense that people with severe mental health issues were treated in institutions and those with less severe issues didn't get a lot of service. That's been changing over time, where it's become much more of a community-based service. But what we've found is that each community tended to operate somewhat in isolation. I think the way we described it is that it's a bit of a patchwork of services out there with respect to children's mental health services.

On slide number 4, what I tried to do is identify for each of these audits what I would consider to be the five key issues. We have a number of other issues in the audit report, but just to try to highlight them, I think probably the number one issue to us on child and youth mental health would be certainly more of a focus on early iden-

tification and intervention. We had feedback from the health agencies that we visited, and this was very much an audit where we spent time out looking at these mental health agencies. They indicated to us that was an issue. They also indicated to us, though, that they can't handle this on their own; they need the schools involved, they need better teacher training. Australia and the United Kingdom: In their mental health strategies, they've got this in their top three as very important issues.

1610

The second issue that we had: We felt that across Ontario, because a number of the agencies have operated a bit in isolation over time, there was inconsistent intake and assessment, which means that often you could have a child in two different parts of the province having the same basic mental health issue but getting significantly different treatment, or some might have a wait time of a month whereas some were waiting six months for an assessment.

The third area was wait lists. A bit of good news and bad news here: We found that there were fairly long wait-lists of three to six months for non-residential services, but for residential services the wait times were actually quite good. They were short and, in some cases, they could get people in right away. So it was a bit of a good news/bad news with respect to wait times.

The other thing we pointed out was that there's definitely a lack of what we would call evidence-based treatment programs, in the sense that a number of these children, the mental health issues they have—they deal with depression, aggression, anti-social behaviour—there are different ways you can treat those. Some of the other jurisdictions are having a real focus on what works and what doesn't work and trying to disseminate that across the community. We felt there needs to be more of that in Ontario, more collaboration and coordination.

The fifth issue that we identified was that the funding has been very history-based. I guess I'd have to say it's hardly kept pace with inflation over the last decade. The way we described it in the report was the agency has indicated to us that they really had a hard time even just maintaining their core services. They basically said, "We've had to rob Peter to pay Paul," if I can put it that way, to even try to maintain their core services.

Being a kind of fair-minded auditor, though—you'll see on slide number 5 there were some positives. We did note some good things being done, one of these being what the ministry calls service mapping. In 2004, at a PAC hearing—and we looked at this a number of years ago—the ministry had indicated, "It's been some time since the ministry has had a serious look at exactly what services are being provided on an agency-by-agency basis." Even during this audit, the ministry did not have a good handle on what agencies were providing what services, what the availability was or what the wait time was, so it's sort of like until you really know where your major problems are, it's difficult, I'd have to say, to cost-effectively address it. But the ministry has basically recognized that and they're doing a detailed service

mapping on an agency-by-agency basis to try to get a handle on that. So we felt that was a really important first step.

They have implemented a standard intake tool. Basically it's a brief child and family phone interview. They're trying to put that across all the agencies to get some consistency and they're also using a case assessment tool, CAFAS, which they're trying to use across all the agencies, again, to try to get more standardized assessment, which we thought was good news.

We did note some good practices at some of the agencies. For instance, a few of the agencies were taking this CAFAS data and they were trying to use it to come up with good, evidence-based practices. But again, there's really no way right now of getting that collaboration across the whole system. We felt that there were some good ideas, but we felt the ministry had to take a leadership role and try to disseminate some of this good information.

Turning to community mental health, which is basically adults, there's about 2% to 3% of the population that has serious mental health problems. The community mental health services are really to address that percentage of the population. Overhead number 6 gives you a bit of detail on the dollars that are involved.

This has been a program where it was also, going back three or four decades, very institution-based. The trend, really, around the world has been to provide these services in a community-based setting. The ministry has actually made a pretty significant effort to move to a community-based setting. The issue with that, though, is when you start moving people out of the institutions, you have to make sure that you have the community-based supports there, or what happens is what we call the revolving door syndrome: They get out to the community, they don't get the treatment, they're back at a hospital, or basically you've got the ACT team having to help them out. We found that there still wasn't an adequate level of community-based support, given the amount of deinstitutionalization that actually has been very successful over the last decade.

The LHINs are involved in this as well. The LHINs responded to us in writing and said that timely access to mental health services remains a principal barrier to effective care in the community. The LHINs basically said, "We recognize this is an issue; it's a problem." There are fairly lengthy wait times for services. It can be up to 180 days. Ministry staff acknowledge that.

There's a critical shortage of supportive housing in some areas, but in some areas you have vacancies. There are inconsistencies across the province, but for the most part, there needs to be more supportive housing. Again, the LHINs told us that affordable supportive housing is the cornerstone of cost-effective community care. Dr. Kitts from Ottawa came to one of the public accounts committee hearings, and he said that you can't just look at hospitals; you've really got to look at the whole area. They asked him about what could be done to make it

better for hospitals, and he said that affordable housing in the community would make a big difference even to a hospital. So that's an issue.

The whole issue of historical-based funding has created significant regional disparities. The LHINs came back and said to us, "We agree, Auditor, that the way the agencies have been funded has resulted in significant inequities across the province in access to service." To give you an idea on a per capita basis, it goes from a high of \$115 down to a low of \$19. You can't base the funding totally on a per capita basis, but I think there's a recognition that there needs to be a new funding model based more on relative needs in the local community.

The last point, number 5, is the funding. Even though we've deinstitutionalized a lot of people, the funding has not followed that deinstitutionalization into the community. Going back about 10 years ago, the ministry felt that to reach our target, which is 35 beds per 100,000 people, we would need to have 60% of our funding in the community. Right now, they're only at 40%. So there's a recognition that we need more community-based funding to provide that level of support. On the positive side, you have to give the program credit, in that over the last 10 to 15 years they have met their deinstitutionalization targets. They're down to about 35 beds per 100,000 people. The downside of that, though, is you have to make sure you have the community-based supports.

Again, as with child and youth, there are some good local coordination practices. We also felt this is an area where they've started to put together some good data collection systems. We did give them a pat on the back for making a good start on that. They've still got some problems with quality of data, but at least they've got the underlying information systems in place to start to collect the data, to know where they stand.

Moving on to addiction treatment services, as you can see on slide number 9, the government spends about \$129 million, and about 90% of that goes to 150 addiction service providers. These are now overseen by the LHINs. In the last decade, there hasn't been a significant increase in the amount of funding going to substance abuse. On the other hand, problem gambling has had quite a substantial injection of funding, because 2% of the revenue from slot machines at the racetracks goes to problem gambling. Some of the feedback we had on substance abuse is that we've got growing demand, and again, the same thing: We're having a hard time just keeping our core services.

The other thing that came up too is that these local agencies have evolved over time. It hasn't been what I would call a planned, coordinated approach. The last time we did the audit in 1999, we saw that the other jurisdictions were merging a number of their smaller treatment centres into larger, multi-faceted treatment centres, because people with addictions also often have mental health problems, they could have law enforcement issues, and they need more multi-faceted, larger agencies. They said they were going to go that way, but

in the current audit it didn't look to us like they'd made a lot of headway.

With respect to the five key issues, we felt that most of the people needing addiction treatment services are not being identified. In fairness, you can't say, "Well, that's the ministry's fault." Part of it is getting that awareness out, and a lot of people just aren't coming forward saying, "I need help." There's a definite saving, if people need help, on the health care side, on possible law enforcement savings. The empirical evidence says that for every dollar you spend, you can save anywhere from \$4 to \$7.

On the wait times, it's probably good and bad news. I'd have to say, on one hand, there were some significant wait times, but it was actually much better than community mental health. People were getting in quicker to get an initial assessment on addiction treatment services than they were on the mental health side. Having said that, you could still wait up to six months. But the average was about three to four weeks, which was definitely better than community mental health.

1620

On the LHIN per capita funding: again significant inconsistencies between the different LHINs, because it's been historical-based as opposed to needs-based, and the range has gone from basically \$40 per capita in the highest LHIN to \$3 per capita in the lowest LHIN. Again, the feedback we had from the LHINs was, "You can't do it on a strictly per capita basis, but we recognize that right now there are some significant inequities in the way we fund things." The ministry is looking at it—I think they call it HBAM, historical-based allocation model—to basically try to address that. There is some recognition, but they've kind of indicated, "It's going to take us a couple of years."

What we noticed too, with the transfer to the LHINs—they've shut down all the ministry regional offices—is that that there has been some loss of corporate knowledge, as well as the ability to oversee these providers. For instance, on the addiction treatment agencies they used to get an annual operating plan, saying, "Here's how we're going to spend your money." The last two years they basically stopped that requirement of getting the annual operating plan.

They've also lost some knowledge, and that would vary by LHIN. The central LHIN actually did a very good job. They picked up a number of the ministry regional health people. But some of the LHINs haven't been so lucky, either because of funding or they haven't been able to get the people.

Again we felt, with respect to addiction treatment services, that there needed to be better coordination. There wasn't a lot of information at the ministry with respect to availability of service: "Where are our gaps?"

But we did see some positives. Again here, we felt that there were some good information systems that had some good potential. Especially ConnexOntario is doing some good work.

We had to say, "You know what? There's definitely been significant recent attention on problem gambling." They've definitely pumped a fair bit of money into it and they've taken a pretty aggressive stance on problem gambling. The big concern they have is that there has been limited uptake. Maybe "concern" is not the right word, but there's a feeling that there are problems out there but people aren't coming forward.

As I've said here, it's probably a positive side. While we have some longer wait times, it's better than mental health.

In my last slide I kind of tried to say, "Well, okay, Auditor, you looked at all these different areas. If you had to pick the top three issues, what would they be?" So we kind of talked about it and decided that of the top three issues, we felt number one would be early mental health identification and intervention for our young people. If you can get people early, and get them intervention and treatment early, it can make a big difference for a lifetime, both for society's benefit and the person's benefit, and also from a cost-benefit point of view.

The second thing we felt was still pretty significant was the significant deinstitutionalization. We felt that the community supports still were not up to where they probably should be for the adult mental health, and even the hospital community came back to us and said, "We know that we've got probably 10% to 15% of people in the hospital with mental health issues who could be in the community if we had the supports."

The last thing here that we noticed across all three programs was that—more needs-based funding as opposed to historical-based funding, because there are a lot of inequities in the system.

I've kind of rambled on for about 15 minutes. I'd be happy to take any questions you might have.

The Acting Chair (Mr. Bas Balkissoon): Thank you. Ms. Elliott?

Mrs. Christine Elliott: Thank you very much, Mr. McCarter, for your presentation. It's extremely helpful to us as we're working through this whole process. You have a particularly good vantage point from which to see things.

I just had two quick questions. One was on children's mental health, and you mentioned better teacher training for children in Australia and the UK as being good examples. Were there any specific studies that you could point us to?

Mr. Jim McCarter: What we were looking at—I think I was looking at national strategies from the UK and Australia. In both, I was looking to see what their top issues were. Actually, when you look across the studies by parent groups, by UK, by Australia, even someone like—I had a good chat with Agnes Samler, who is a former child advocate, but she was retired, so she could be very honest and open. That was her number one too. They all basically said, "You've got the treatment agency, but very often it's the schools that have to identify where you have problems."

But often teachers are really overloaded, and a lot of them don't necessarily have the training to be able to do that. So it's working, I think, in partnership with the schools and family physicians, and trying to get that identification there and get them referred to the provider agencies. So if you've got a child that has anti-social behaviour or aggression or DDD, all these different things, you can get the treatment started at an early stage. But I would refer you to the UK and the Australian national studies, because they kind of have a good list. I think the UK has their top 10, which is quite interesting.

Mrs. Christine Elliott: Thank you.

Ms. Sylvia Jones: I actually wanted to go back to—I don't know if you referenced it in your slides. "The majority of addiction service providers did not," as required, "report wait times for some or all of their services": That's out of your original report. Can you expand on that?

Mr. Jim McCarter: Yes. I might get Rudolph to help me out. There was a requirement that they were basically—part of the funding is you're supposed to report your wait times, but I think three of the four that we visited weren't reporting their wait times through to what's called ConnexOntario, and they were supposed to be tracking that—and also availability of services. Again, we said, "You need to have a lot of that really hard data to be able to know how good a job you're doing and where your needs are. How can you allocate the funding better if you don't have that data?"

Ms. Sylvia Jones: Do you think that was as a result of the switch to the LHINs?

Mr. Jim McCarter: I would have to say it probably wasn't, in the sense that if I was to go back, four years ago, I suspect they weren't reporting the wait time there either. But what I'd have to say with respect to the LHINs is, they probably have less capability now to maybe oversee the addiction service providers than they did before because they've lost some of that corporate knowledge. But on the other hand, the benefit they do bring is that local knowledge to try to address the whole issue of having a more seamless, coordinated delivery of service.

In the long term, I think that's the philosophy, and the LHINs basically said, "We know where we're going, but in the short term, we're struggling a bit," if I could put it that way.

Ms. Sylvia Jones: Yes, I agree. I guess in the situation that I'm faced with, LHINs can't coordinate services that aren't there. It's great that they want to play that coordination role, but if the community-based services are not accessible, particularly with children's mental health, then we can't refer them to something that doesn't exist.

Mr. Jim McCarter: The LHIN CEOs basically said to us, "Mental health is a big issue with us; it's a high priority. We have to get a handle on it." We said to some of them, "Well, it's part of your role to reallocate money if need be to look at the high-priority areas in your local

community,” and they said, “Yes, that’s one of our roles, but we’re not there yet.”

Ms. Sylvia Jones: Now, did you feel that that was part of the LHINs’ role? Because when I’ve spoken to them, they have said, “Part of our job is not to advocate for additional resources in particular areas.” You’re getting a different feel?

Mr. Jim McCarter: My sense was that if they felt—and they indicated to us, with respect to mental health, that they felt that there were concerns. My sense was that they were struggling. My sense was that it was their job to make that known, that if there were issues in their community, they could go forward and say, “We’re wrestling with this. We’re trying to provide this coordinated service.”

They said to us very clearly, three of them, even, in a joint statement: “The services across Ontario—we believe there are inequities in service, and it’s due to the historical funding model.” Some of them said, “We don’t necessarily agree, Auditor, that you can just do it on a per capita basis. It’s too simplistic.” They said, “You have to look at demographics and the different things.” But they basically said, “The way it is now, there are definitely inequities, and we’ve got to somehow get that resolved so that two children with identical needs have a pretty consistent wait time and are entitled to a consistent level of service.”

Ms. Sylvia Jones: Do we have access to that part, the three LHINs and their report to you?

Mr. Jim McCarter: It would be in the detailed report, the three LHINs that would have said that. If you go to the response—that would be in the response to the recommendations, where they would have said that.

Ms. Sylvia Jones: Okay, thank you.

The Acting Chair (Mr. Bas Balkissoon): Ms. Jaczek?

Ms. Helena Jaczek: Yes, looking at slide 8, under your positives, number 3, the “2007 mental health scorecard and two new data collection systems are good initiatives”: We did actually have the deputy from MOHLTC here and we didn’t get too much information on this. I was wondering if you could expand—

Mr. Jim McCarter: Yes. The mental health scorecard: What they’ve done is they’ve got 29 performance indicators where they’re going to try to track what the results are. It could be that the reason the deputy didn’t get into it too much is that it’s just getting off the ground.

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We said in our report that what they’re trying to do is a good idea, but they’ve really only got half of them where they even know exactly what data they want to collect. At least they’ve identified that. My feeling on all of this is you have to define what is success and what is reasonable. In a pragmatic, reasonable way, how would you define success in community mental health? How would you define success in addiction treatment services? It looked to us like, on the mental health scorecard, they were trying to do that.

It’s the same thing with respect to the services being provided, like in children’s mental health. There are no standard services, no legislated services. We sort of said to the ministry, “You really need to, at some point, decide what services will or won’t be provided, what’s the level of service that you’re aiming at. If you don’t try to set up some consistency there, again, you’re going to have every different municipality delivering different services in different areas, having different priorities.” That’s the mental health scorecard.

The other two: They’re trying to develop common data sets or common data elements. Again, whereas on the addiction side, where they’re doing a better job, they’re actually starting to collect individual client data, which is really helpful, they’re not there yet on the mental health side, but at least they’re collecting aggregate data. We have problems with the reliability of the data, but at least they’re making a start. Would we say the data’s reliable right now? Probably not, but at least they’ve recognized that and they’re trying to tackle that issue.

Ms. Helena Jaczek: So is the goal of the mental health scorecard that it will be used on each individual client?

Mr. Jim McCarter: It seems to be more of a high-level scorecard. I see Rudolph nodding, but to get to that high-level scorecard, you need to have the data from the individual providers to be able to roll it up. Then you can start looking at it on a LHIN-by-LHIN basis to see with respect to funding and where we have service gaps, but you need that underlying data, and it has to be reliable.

The Acting Chair (Mr. Bas Balkissoon): Ms. Gélinas?

M^{me} France Gélinas: I have to congratulate you because I’m one of the people who sit on the committee, and I would say your top five key issues and your three concerns would have been mine also. Very well done, and a very helpful little one-page thing that sums up lots of hard work.

You’re an auditor, you’re very good at crunching numbers—

Mr. Jim McCarter: I know.

M^{me} France Gélinas: —and you have talked about inequity, from \$19 to \$117 per capita on a historical basis. We all agree that per capita is too simplistic. In your work, have you come across a good list as to what you should be including? You’ve hinted towards supportive and affordable housing, but what else should we look at if we want equity between all parts of Ontario? Have you come across anything good in that respect?

Mr. Jim McCarter: I have to say, I don’t think anything comes to mind, but I know, in talking to the LHIN CEOs, they all had pretty definitive opinions on what they thought, depending on the needs in their particular area. However, I’d have to say, if you got the 14 of them in a room, I don’t think they’d agree on just how to do it. The answer to you is I can’t refer you to a specific document. I don’t think we have a specific document, and I’ll turn to my colleagues, but—

Mr. Walter Bordne: The way they do it for children's mental health services is, basically, they count kids as one of the justifications for funding. That's very simplistic, again, because a child getting 24/7 supervision in a home program shouldn't be counted the same as a child who goes to counselling once a week or once a month.

Value-for-money, I think, by definition looks at the relationship between what you're getting and what you're paying for. What you're getting is really the hard part because a lot of these agencies are autonomous; they're funded by independent boards. We know roughly the types of services they're providing, but we have no idea as to the quality and really the quantity in a quantitative way. What they have to do, I think, is much more detailed work as to not necessarily how many buildings they have and how many staff they employ but how efficiently and effectively they're used. If, for example, you're paying for a child to go to counselling once a week, and if there are three kids in the session with one counsellor, and a counsellor makes \$100 an hour, one child for that one-hour session should be \$33.

Mr. Jim McCarter: I'll jump in and give you an analogy. I think of long-term care, where they basically take long-term-care residents and divide them into six or seven categories, from people with severe Alzheimer's who need significant care to basically someone who's living there but they don't need a lot, and there's differential funding for that. That would be a more simplistic example.

But even something like that, when it comes to children, what are the relative needs in your community? As Walter said, there's a big difference between somebody needing 7/24-hour care and someone who might be in for an hour of weekly counselling. And I don't have anything I can refer you to—

M^{me} France Gélinas: But you haven't come across anything good?

Mr. Jim McCarter: No. I'm being very honest.

Mr. Walter Bordne: The other issue is it's really a zero-sum game, so to give somebody else more because they really deserve it, you have to take it away from somebody else. That's the other hard part.

M^{me} France Gélinas: But at least we would know what we're shooting for. That would be something, to start.

My second question has to do with children's mental health, and here again, in the work that you have done, I know that the deputants and people talking to your report talk a lot about a mandated basket of core services for children's mental health. Sometimes they talk about legislated services for children's mental health; it has different names. Here again, in your studies have you come across either provinces or other jurisdictions where you find those mandated core services for children's mental health, as opposed to what we have here?

Mr. Walter Bordne: Not in mental health per se, but for example, in children's aid societies those are mandatory services, so children's aid societies have to be

funded to the level of the service that they're providing. If they're short at the end of the year, somehow we have to make that up because we can't turn a child away from a care situation because the money isn't there. So we have to provide that service—

Mr. Jim McCarter: I know what you're saying: Did we come across something like Illinois or B.C., that if you wanted to make that recommendation, here would be a good template to use? The answer to that is no. Some of the jurisdictions are going that way, but we didn't see anything that we would say, "Here's a great template that could be used," which is of maybe a reasonable level of care.

M^{me} France Gélinas: And how about within Ontario: Of the people that you interviewed, are there people who are working towards developing something like this, or are we really on our own?

Mr. Jim McCarter: My sense is they tend to—as you know, these are very dedicated provider agencies. They do what they can as far as providing core services but there's a lot of firefighting in the sense that when little Johnny or little Susan comes in and they've got a real problem, they will drop everything and make sure they see them. But what happens, as I say, is if they rob Peter to pay Paul, then somebody else is not going to get the treatment.

We find that some of the agencies specialize in different areas. We found that there's still not a lot of coordination and collaboration across the system, i.e., a central access point that if I think, "I've got a real problem with my son Colin. Where can I go where they have a central access point and they can tell me the whole range of services, where they can tell me, 'Here's what's available; here's the waiting time'"—that sort of availability is not there, although they are making some attempt, but they still have a fair way to go.

M^{me} France Gélinas: Okay. My last question is—in your top three concerns, you said children's and youth mental health, early identification, and intervention. I'm trying to remember who it was who came and presented and basically said that in other jurisdictions—I think it was Quebec—they test all kids in grade three and they test them again in grade whatever for early identification. They found that this had a tremendous effect on kids acting out later on etc. Again, my question: Do you remember who that was?

Mr. Jim McCarter: I can't remember which jurisdiction it was, but that sort of thing, or more attention. I know even just in talking to Agnes, who's got a lot of experience—30, 40 years' experience dealing with these situations—she basically said that this was a really key issue. She was blunt. She said in getting the school boards onside, you're going to have a challenge because it's going to require some teacher training, once you start implementing something like this. But she said, "In my opinion, Jim, that would make a big difference."

The Acting Chair (Mr. Bas Balkissoon): Members of the committee, I still have two requests for questions. The 30 minutes is up, but I'm happy to carry on if I could

have a motion of acceptance by all committee members to carry on?

Ms. Sylvia Jones: Yes.

The Chair (Mr. Bas Balkissoon): Unanimous consent? Carried.

Okay, Mr. Leal.

Mr. Jeff Leal: Jim, thanks for your presentation. Do we know, in the province of Ontario—do we see a spike in problem gambling with the introduction of slot machines in Ontario? Do we have any baseline information on problem gambling in the province of Ontario?

Mr. Jim McCarter: I'm not sure that they have good data on that. They are pumping major money into it in the casinos. The issue is that there just isn't a big uptake. It's kind of like, why isn't there more uptake? We think the problem's out there. We think it's out there, but we don't have the uptake.

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We didn't come across anything which was solid enough for us to put in the report, saying, "Problem gambling is becoming more and more serious in Ontario." We didn't come across anything that gave us enough support to say that. The suspicion is kind of there, but we didn't have enough evidence to say that.

Mr. Jeff Leal: My next question, just as a follow-up: Over the years, you've looked at the activities of OLG. Maybe I should know this, but does OLG have a system to monitor or to identify clients using their sites as problem gamblers?

Mr. Jim McCarter: No. Actually, we haven't been the auditors of OLG now, I'm guessing, for about 15 years. But I suspect that they wouldn't have that system, and it could be because of privacy. I know what you're getting at. Also, if I can put it this way, do they track the demographics of the people who buy lottery tickets, how much do they buy, and with what percentage of their income?

I know where you're heading with that, but I don't know if they track that.

Mr. Jeff Leal: I'm trying to see a correlation between—you know, we're taking money from the proceeds of gaming in the province of Ontario to use it as treatment and to find the people we're trying to treat.

Mr. Jim McCarter: Yes, and they're taking 2%. They're actually living off about a third of that to go to the Ministry of Health Promotion—I think it's about a third.

Mr. Jeff Leal: I just noticed on your summation sheet, you had said one service provider served only three clients per counsellor at a cost of \$26,000 per client for the year.

Mr. Jim McCarter: Yes, we noticed that in a number of the areas, where you'd have residences where they would have eight staff and two people in the residence. We've got a smattering of those types of details on all three areas, but we noticed it with the ACT teams. Do you know the ACT teams? Some of the ACT teams are very busy; other ACT teams had more staff than they had clients.

So again, the part of that that gets to us is the overall monitoring of all the stuff. As auditors, I guess we look for that, saying, "How do you control that? How do you know you're getting good bang for your buck?"

Mr. Jeff Leal: Well, it's the old value-for-money-type—

Mr. Jim McCarter: Yes, when you see examples like that, we'd have to say, "Well, surely you would have asked the question."

Mr. Jeff Leal: Thanks.

The Acting Chair (Mr. Bas Balkissoon): Ms. Jones.

Ms. Sylvia Jones: Just a quick question: On slide 5, under "Some positives" you say, "Service mapping by ministry under way." Is that Ministry of Children and Youth Services or Ministry of Health?

Mr. Jim McCarter: Ministry of Children and Youth Services. They had said about five years ago that it's been some time since we've had a serious look at exactly what each agency is delivering. They didn't have a good feel, not only on the service availability or the wait times; they didn't even know what services each agency was delivering. I mean, maybe it's kind of a backhanded pat on the back, but it's kind of like, "It's good you're doing it, but it's about time," if I can put it that way.

Ms. Sylvia Jones: And is there a timeline on when that is expected to be finished?

Mr. Jim McCarter: They were before the public accounts committee. I think they indicated that they were still looking at probably another year, to get all the data in. But there are comments on that specific issue in the Hansard of that particular meeting at public accounts.

Ms. Sylvia Jones: Thank you.

The Acting Chair (Mr. Bas Balkissoon): Thank you for taking the time to be here.

Mr. Jim McCarter: Thanks very much for the invitation.

SUBCOMMITTEE REPORT

The Acting Chair (Mr. Bas Balkissoon): Committee, we have a couple of pieces of business to do. Subcommittee report: Ms. Jaczek, can you read it into the record? No? Oh, Mrs. Van Bommel, can you read it into the record?

Mrs. Maria Van Bommel: I'd like to move the report of the subcommittee on committee business.

Your subcommittee on committee business met on Tuesday, May 12, 2009, to consider how to proceed with public hearings in Windsor, St. Thomas, Hamilton and Kingston, and recommends the following:

(1) That the committee start its hearings in Windsor on June 15, followed by St. Thomas on June 16, Hamilton on June 17 and Kingston on June 18.

(2) That the committee clerk arrange a site visit of the Regional Mental Health Care hospital in St. Thomas on June 15, following the hearings in Windsor.

(3) That groups and individuals be offered 20 minutes for their presentations, including time for questions.

(4) That the committee clerk contact groups from Toronto, Mississauga, Chatham and London that requested Hamilton, and inform them that the committee is oversubscribed in Hamilton.

(5) That the Chatham and London area groups that requested Hamilton be accommodated in St. Thomas and Windsor—and that's a correction to the written document.

(6) That the Mississauga and Toronto area groups that requested Hamilton be added to the list for the Toronto hearings.

(7) That the committee clerk, in consultation with the Chair, be authorized, prior to the passage of the report of the subcommittee, to commence making any preliminary arrangements necessary to facilitate the committee's proceedings.

The Acting Chair (Mr. Bas Balkissoon): Any comments? Can I have a motion to adopt the subcommittee report?

Mrs. Maria Van Bommel: I so move.

The Acting Chair (Mr. Bas Balkissoon): All in favour? Carried.

A couple of housekeeping things: Distributed today in your package are the follow-up answers of the Ministry of Health Promotion. You also have a paper from research.

Just a reminder: On May 27, we have to be at CAMH at 12:30. The committee clerk will be in touch with members re travel arrangements.

Mrs. Liz Sandals: This is the 27th?

The Acting Chair (Mr. Bas Balkissoon): May 27, and the time we have to be there is 12:30, so I assume we'll be leaving here about 12 or 12:15.

Interjection.

The Acting Chair (Mr. Bas Balkissoon): We will get instructions.

That's it. We're adjourned—no, sorry. Ms. Elliott?

Mrs. Christine Elliott: If I could just raise one item. I have received a request from the Schizophrenia Society of Ontario to appear before the committee. I would ask that the committee members consider that and I would ask for a favourable recommendation.

The Acting Chair (Mr. Bas Balkissoon): Susan, you have a comment?

The Clerk of the Committee (Ms. Susan Sourial): Here in Toronto?

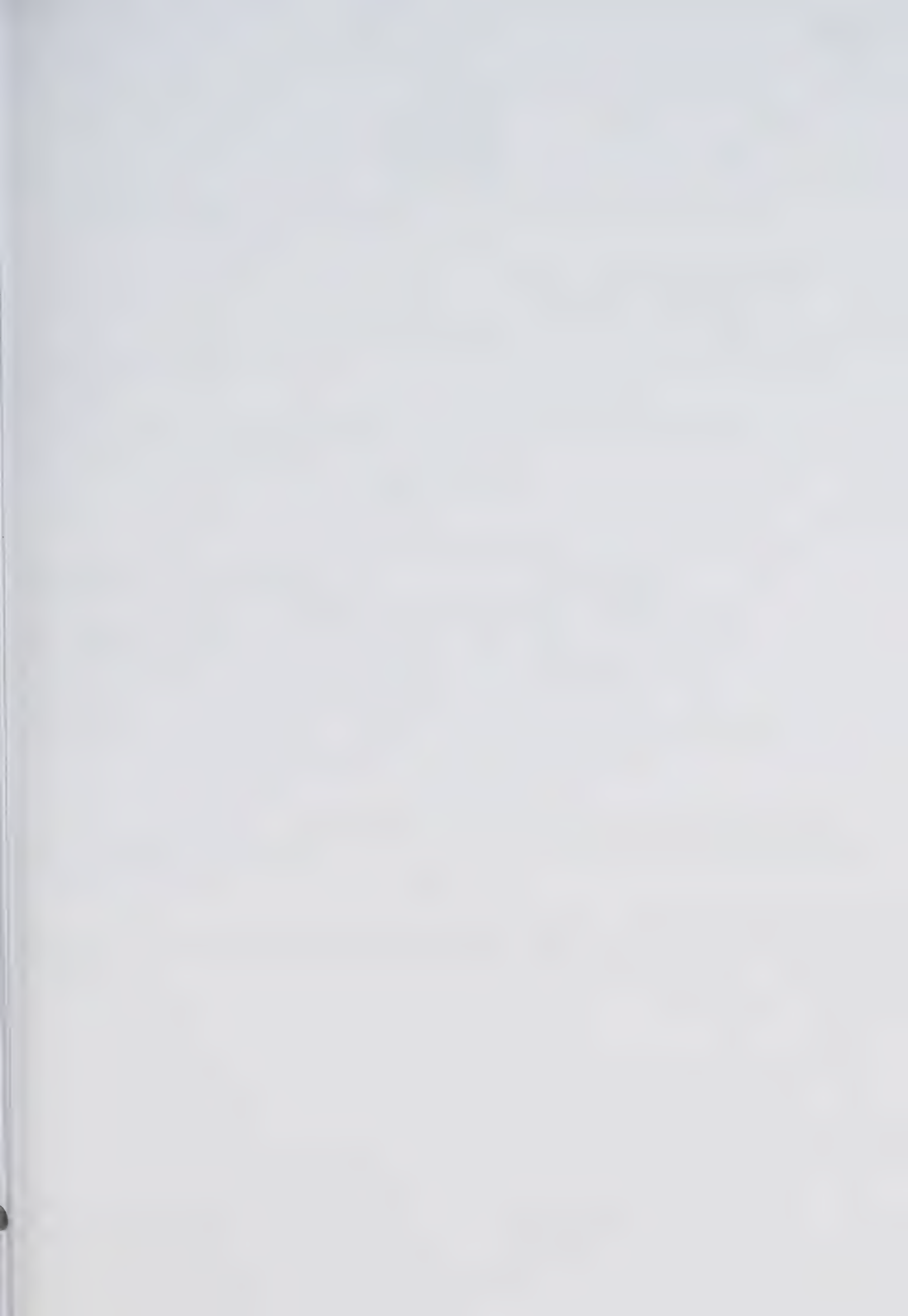
Mrs. Christine Elliott: Yes.

The Acting Chair (Mr. Bas Balkissoon): If you could just ask them to contact the clerk's office, and they'll be put on a hearings list for here.

Mrs. Christine Elliott: Okay.

The Acting Chair (Mr. Bas Balkissoon): Okay? Anybody else? We're adjourned.

The committee adjourned at 1644.



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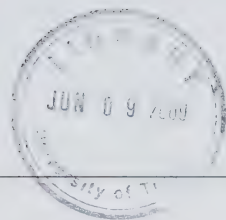
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ISSN 1918-9613

Legislative Assembly of Ontario

First Session, 39th Parliament

Assemblée législative de l'Ontario

Première session, 39^e législature

Official Report of Debates (Hansard)

Wednesday 27 May 2009

Journal des débats (Hansard)

Mercredi 27 mai 2009

Select Committee on Mental Health and Addictions

**Mental health and addictions
strategy**

Comité spécial de la santé mentale et des dépendances

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LEGISLATIVE ASSEMBLY OF ONTARIO

SELECT COMMITTEE ON
MENTAL HEALTH AND ADDICTIONS

Wednesday 27 May 2009

The committee met at 1707 in committee room 1.

COMMITTEE BUSINESS

The Chair (Mr. Kevin Daniel Flynn): Okay, ladies and gentlemen, if we could all take our seats. With the indulgence of our guests today, I wonder if we can just do some brief committee work for your information.

We've had a late request from a group from Huron Perth Healthcare to be part of the delegations in St. Thomas. The clerk, Susan, sent out a request. The only thing we received back was people saying they were good with it or people not saying anything at all, so I'm assuming everybody's okay with the addition to the St. Thomas agenda. Okay.

Just to let you know, we invited the Speaker to join the committee during our site visit in St. Thomas, because it's his riding obviously, and the Speaker has accepted our invitation.

The people at St. Thomas have asked us what the focus of the tour should be when we're there. The four things they deal with there are forensic psychiatry, mood and anxiety disorders, assessment programs and psychosis programs. I made a bit of an executive decision and decided we'd like a little piece of each, unless there are any objections? It seemed to me that we don't know enough to know what we want to know. I'm assuming you're okay with that.

The subcommittee needs to meet regarding travel to the First Nations reserves, and we were wondering, Jeff, if we could involve aboriginal affairs in a subcommittee meeting to maybe pick out some of the appropriate reserves.

Mr. Jeff Leal: Absolutely. They'd welcome that opportunity, Kevin, for sure.

The Chair (Mr. Kevin Daniel Flynn): Okay. So maybe we could arrange that before the House rises?

Mr. Jeff Leal: Yes. We'll make ourselves available.

The Chair (Mr. Kevin Daniel Flynn): Okay. That's all the committee business I have, then.

M^{me} France G  linas: Mr. Chair, I brought a map of all the reserves in northern Ontario. I'm just going to pass it around so that at least when we say names like Bearskin Lake and Muskrat Dam and all of that, you'll know where we're talking about and how far they are.

Mr. Bas Balkissoon: And we've got to get there by canoe.

ASSEMBL  E L  GISLATIVE DE L'ONTARIO

COMIT   SP  CIAL DE LA SANT  
MENTALE ET DES D  PENDANCES

Mercredi 27 mai 2009

M^{me} France G  linas: With a GPS, you can get there, no sweat.

The Chair (Mr. Kevin Daniel Flynn): Some members were asking about the exact schedule for when we're travelling in June, Bas. I think we have that nailed down, and the clerk would be happy to let you know.

Mr. Bas Balkissoon: Yes, if we could get it, that would be great. It will help with some planning.

The Chair (Mr. Kevin Daniel Flynn): Yes. The only holdup is we're still trying to find a place to meet in St. Thomas. Apparently we don't have approval yet on a meeting room. We have to get a permit for it, and that appears to be forthcoming.

Mrs. Liz Sandals: Yes, the when and where.

The Chair (Mr. Kevin Daniel Flynn): Yes. Okay, so that should be coming out very shortly.

MENTAL HEALTH
AND ADDICTIONS STRATEGY

MICHAEL KIRBY

The Chair (Mr. Kevin Daniel Flynn): Thank you for your indulgence, Mr. Kirby. Today we've got Senator Michael Kirby with us, chair of the Mental Health Commission of Canada, much talked about in a very positive way and certainly one of the first people who we wanted to hear from when we were starting our own deliberations. As with everybody else we've had before us, you have 30 minutes to use up any way you see fit, Senator. As we talked about earlier, the committee does like to ask questions, so I'll turn the floor over to you. Welcome.

Mr. Michael Kirby: Thank you, Mr. Chairman, and may I say to members of the committee that I'm delighted to be here. It's been a number of years since I've testified before a provincial committee, done it many times federally, but I'm delighted to be here.

Because I know you want to ask questions, I'm going to make a very brief statement, which I hope will also lead to some questions, and then answer your questions. I have distributed an opening statement, which, mercifully, I'm not even going to mention. The opening statement essentially tells you what the Mental Health Commission does, because I thought that was one of the things you wanted to know.

I think really what I want to do is make two main points. The first is that mental health services everywhere in the country are grossly underfunded. Let me just give

you two or three interesting statistics, only because some of the facts about mental health are sufficiently surprising that most people are quite stunned by them. Perhaps the most amazing one is what I call the hospital days. If you look at the total number of hospital days in Canada in which the hospital bed has someone in it who has a mental illness, that total number of hospital days actually exceeds the total number of hospital days for everybody who's in the hospital with cancer and heart disease combined. The reason for that is because typically an individual with mental illness is in for a fairly lengthy stay, and typically a person with cancer or heart disease is not. Nevertheless, that gives you some relative measure of the size of the economic burden on the health care system, and yet mental health itself hardly gets mentioned and, in most cases, doesn't get touched. Only 5% of the research money that is given out by CIHR, the Canadian Institutes of Health Research, goes for mental health—5%, in spite of a comment that I just made to you on hospital days and in spite of the fact that the economic impact of mental illness in Ontario—and here I'm referring specifically to employers' days lost because people are on short-term disability, days lost because people are sick, very frequently with some sort of mood disorder, such as anxiety, depression, stress and so on, and days lost because people actually show up at work and are suffering from what is typically called presenteeism, which means they're there in body but not in mind, and so the productivity goes down.

Two years ago there was a study done which showed that the economic impact of mental health on Ontario workers alone cost the Ontario economy \$33 billion. So when you look at the economic impact and look at the hospital impact, you have to say to yourself, why is it that public policy, research money and funding are so far behind the rest of the health care system? There are two reasons for that. The first is the stigma that's attached to mental illness. The fact of the matter is that because the stigma is so bad—and let me just tell you, if you talk to most people with a mental illness, they will tell you about the stigma and discrimination that they face from their family, friends and co-workers, so not strangers. Family, friends and co-workers are frequently harder on them than the illness itself. So stigma is a driving variable.

The second one is the way government's organized, and I would hope you will do something about this as you go down the road. There is clearly a complete lack of a single point person or department in government who is responsible for mental health services. The health department provides those services that deal with doctors and hospitals. Community and social services provides those services that deal with community-based services. Somewhere else, your housing department provides services that deal with supportive housing, and so on.

Let me make an observation to you, having sat around cabinet tables federally and provincially. When you have an issue that comes up in which a whole variety of cabinet ministers own a small piece, but not the whole piece, their entire focus is arguing for their department on

the things that they have the whole piece for. This is not unique to Ontario; this is true everywhere. So the blunt reality is that there is no spokesperson at the cabinet table for mental health. In the absence of a central focal point, it will be very hard to get the resource issue properly straightened out, and I would hope that's an issue that you would address in your final report.

A second comment is that there are three specific areas where services are desperately needed. The biggest and most important is supportive housing. What we did in this country—Ontario is no exception—was, in the late 1980s and early 1990s we closed institutional beds, the so-called asylums that we all had across the country. The intent had been to replace those beds with community-based beds. We closed them at a much faster rate than we opened the community-based beds, and the result is—and it truly troubles me to say this—that in Canada, we have made the streets and prisons the asylums of the 21st century, because vast numbers of those people either end up on the street or in prison, and they end up going from one to the other. The odd result of all of that is that, in terms of front-line workers, for people who first enter the mental health system, the two groups of front-line workers are roughly general practitioners, who get 70% to 80%, and the police, who get the other 20%, because they get picked up and charged with something. So supportive housing, that's just where we've got. You've got to build the beds that were supposed to be built 10, 15 and 20 years ago, and that requires money into supportive housing.

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The second comment is, you've got to increase children's services. By far the worst part of the mental health system is the children's system. A couple of numbers that are worth keeping in mind: 70% of adults with a mental illness had the first episode with that illness when they were a child. If that illness was properly diagnosed and treated, not only would the individual be substantially better off, the money you would save government is colossal because you would get those people to the point where they were able to live a reasonable life in much the same way that you get someone who has diabetes able to live a reasonable life through insulin, diet or whatever, and you would save society all the money that comes down the road when an individual becomes an adult because the mental illness continues to deteriorate and has a more serious issue down the road.

So I absolutely think you have to do something about kids' mental health. You have in Ontario a unique resource that the Mental Health Commission has been taking advantage of. It's called the Provincial Centre of Excellence for Child and Youth Mental Health at the Children's Hospital of Eastern Ontario. We at the Mental Health Commission have been using their skills in a whole variety of ways, and I think it would be important that you acknowledge the value of that institution. Although they're funded by the government of Ontario and defined as a provincial centre of excellence, the fact is, they've really become the national centre of excellence.

The third thing I would urge you to do is look at improving the way community services are both funded and delivered. Now, having said that, I think you've got to make some changes in the way the services are actually delivered. One of the problems with community-based services is that there are so many different little agencies doing them that there's a considerable amount of inefficiency in the administrative overhead. It would be possible to deliver the same services, either improved in quality or improved in number, with a serious consolidation of the number of players on the ground.

As all of you know, trying to change a silo-driven system is not easy because they're all in favour of progress; it's just change they don't like. The result of that is that it's very hard to get change accomplished on the ground. One of the key tasks of the Mental Health Commission is to develop a national mental health strategy, and we will in fact be dealing with the issue of how you deal with what is very much a silo-driven system on the ground.

To summarize, if you can get a single point in government, if you can increase supportive housing, do everything possible to help improve the quality and quantity of children and youth mental health services and do something about making community services better organized and more easily available, you would do a heck of a lot for the people in this province who are living with a mental illness.

I'd like to stop there, Mr. Chairman, and then take as many questions on any subject that people want to throw at me.

The Chair (Mr. Kevin Daniel Flynn): That's wonderful. Thank you, Senator Kirby. We've got about six minutes for each of the parties. Why don't we start with you, Sylvia?

Ms. Sylvia Jones: Thank you. I appreciate you coming today, Senator Kirby. It's very helpful as we begin this process. I was wondering if you would elaborate more specifically on the children's services aspect. I'm hearing some interesting things coming out of—I think it's Australia and Ireland on some of the things that they're doing, and I wonder if your commission got into that kind of detail or has some specific recommendations.

Mr. Michael Kirby: The answer is yes, I do. I don't have them with me. I'm a firm believer in not reinventing the wheel. We're going to take the best ideas that are being used anywhere. You're quite right: Ireland and Australia and New Zealand are doing superbly well in this regard, as is the US, on the issue of how you deal with people who have both a substance abuse problem and a mental illness. There are very good examples around the world, and if you give me your card when I leave, I will actually have somebody get in touch with you and give you some quite concrete proposals in that regard.

Ms. Sylvia Jones: Excellent. Thank you.

The Chair (Mr. Kevin Daniel Flynn): France?

M^{me} France Gélinas: I'm most interested in the health promotion and disease prevention aspect leading

to mental health. I was wondering if, in the work you have done, you have come across any best practices, any champions, specifically in promotion and disease prevention, so that people do not develop mental illness, or what we call secondary and tertiary prevention; that is, you already have a diagnostic, but what do you do so you don't get some of the complications that come with being diagnosed with severe depression or whatever. Have you come across any of this, do you know some best practices, do you know some champions etc?

Mr. Michael Kirby: The short answer, again, is yes. There are a number of isolated good examples around the world. Clearly, by the way, if you're going to deal with the mental health problem, you're going to deal with the health care problem. This country cannot afford the health care system we have for a heck of a lot longer unless we start really promoting people being well rather than promoting a policy that says, "Fix them up when they're sick." Do you have to do mental health promotion? You absolutely do.

There are some good things. For example, we're now working with a couple of employers to find ways of improving mental health in the workplace, because the \$33 billion I talked about is actually a cost to the Ontario economy, most of which is frankly being paid by private sector employers.

One thing you might want to think about: Governments never think of themselves as employers; it's just not part of the way governments think. The reality is, you're the biggest employer in the province of Ontario, and I would think that the government of Ontario ought to be leading the fight to improve mental health in the workplace, simply because it's the right thing to do for your employees and it's a big cost-saver.

Do you wonder why it's a big cost-saver? All of you understand how benefit packages work, and you know that if someone goes on long-term disability, that's an insured service. If someone goes on short-term disability, typically what you do is continue to pay their salary—their wages—until they come back. Secondly, in many cases—for example, if you're a teacher—they actually have to hire a substitute teacher to replace you. So they have to pay the salary twice.

We've been working and have come up with a way of actually managing those cases better, so that individuals get back to work, on average, 15 days sooner. If you start saving two or three weeks' salary, even if you don't want to do it because it's the right thing to do, you'll want to do it for economic reasons. So a number of big employers are now beginning to focus on the question, because mental illness, particularly mood disorders, is the fastest-growing part of their health care system, in terms of short-term disability but also in drug costs.

If you look at the part of pharmaceuticals in a typical employer's drug plan—again, you have one, and you're the biggest employer in the province—just ask them to give you their breakdown about which drugs are going out fastest. You'll find they're all in the mood-altering category—the antidepressant, anti-anxiety category.

Again, think of the money you could save if you improved it.

The short answer to your question is: (1) there are some very specific things that can be done at the workplace level, and I think the government ought to do that for itself, and not just impose it on others, which would be a standard government strategy; and (2) I will actually get you—we're just in the early stages of going into the mental health promotion side, so if you keep in touch with me down the road, before you're finished your report, we will have stuff for you.

M^{me} France Gélinas: Okay. But so far, there are no champions for this cause or no best practices?

Mr. Michael Kirby: Well, yes. Is there a champion? Not, I think, in the sense you mean of a leading public figure who comes out. There are a lot of champions, particularly in the United States and Australia, where people and governments have started to argue very strongly in favour of increased mental health promotion, but it's early days. Again, historically what happened was that everybody involved in health care focused on fixing you up, not stopping you from getting sick in the first place. So it's early days, but clearly that's where the trend is going.

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M^{me} France Gélinas: Okay. I may have other questions after, but I'll let it go.

The Chair (Mr. Kevin Daniel Flynn): Super. Maria?

Mrs. Maria Van Bommel: Thank you for coming today.

You talked about how services are delivered. Coming from a rural riding—and I know it's the same approach in the north—delivery of services, especially specialized services, is very difficult. I don't think most people understand that even within psychiatry there are specialties. When we have children or adults in our communities who need services, we don't necessarily have the specialty available that we need, so we give something rather than nothing. The diagnosis may not necessarily be accurate or correct, but it is something, and parents who deliver suicidal teenagers to a hospital and say, "Please help me. My child is experiencing difficulties," take what they can.

One of the things that the same hospital would do if someone presented with a broken leg or a broken arm in our situation would be to electronically send an X-ray to a radiologist, in the city of London in my case, and the radiologist would have a conversation with the local GP and decide what's going on.

Is there room in the system, or is it a possibility, to do the same thing, where a psychiatrist in a rural community who has more of a general practice could refer to a specialist somewhere and have the specialist, by an audio-video type of teleconferencing mechanism, be able to provide therapy for a family, for a child?

Mr. Michael Kirby: Yes.

Mrs. Maria Van Bommel: When you talk about resistance to change, I am concerned that some people might say that they want the one-on-one.

Mr. Michael Kirby: I want to come back to your reference to psychiatrists in a minute, but I want to go back to Ms. Gélinas's riding. We are hoping, with the help of the federal government and potentially the Ontario government, to actually run in some of the remote areas that Ms. Gélinas talked about. She talked about reserves, but she also had some communities up there that are not reserves.

If you think of the notion of telemedicine, telepsychiatry is actually the best part of medicine for which to use the system because it's the one part of medicine in which the caregiver does not actually have to have their hands on the patient. With today's modern video conferencing facilities, you can do an extraordinary job.

What we're hoping to do, and launch, before the end of the year is a pretty detailed comparison. We'd like to do it both in some aboriginal communities and some non-aboriginal communities, in part to understand the cultural difference between the two. A psychiatrist from CAMH would actually be in Toronto, but the facilities would be locally done, and you would have a local nurse practitioner up there, or whoever runs the local clinic would be able to provide service.

Let me just comment on the psychiatrist question. One of the mistakes—in retrospect, it's a mistake: Medicare pays for doctors and hospitals, full stop. The reality is that the vast majority of mental health services aren't provided by doctors. They're provided by all kinds of other health care workers. We have people from the Canadian Mental Health Association in Ontario commenting, and they will tell you all the services they provide that aren't provided by doctors. None of those services are insured under medicare. But if you think of the kind of, let me call it, talk therapy, the kind of work that goes in when you do a session with a psychiatrist, there are literally hundreds of psychologists and social workers in this province who can do every bit as good a job, assuming that the individual does not have an extreme mental illness but in fact has the kind of illness for which talk therapy can be pretty effective. None of those people can get that service paid for because the people who are giving them the service, if they're not psychiatrists, are not paid for. The result is that we have the absolute classic two-tier health care system with respect to mental health, because people with income can afford to send their children to a local psychologist, a local social worker who does counselling—because you'll probably wait a year to get a child psychologist, which, by the way, when someone is threatening suicide, is hardly desirable, to put it mildly. And even for an adult psychiatrist, you'll wait darn near close to a year; it may be a little less.

So there are two issues here: First, can you at least, for children, get the service—because I understand the expense, but at least for kids, can you get the services of psychologists and counsellors like social workers paid for? Because otherwise, frankly, unless you do something dramatic like that, solving the children's problem will be almost impossible because there are so few child

psychiatrists around; and secondly, can we do the kind of stuff we want to do in your rural area?

The Chair (Mr. Kevin Daniel Flynn): Okay. Jeff?

Mr. Jeff Leal: To the senator, I know in your review you spent some time looking at mental health services for First Nations communities. If you were to pick three things that we could do immediately to service First Nations communities, what would they be, based on your experience?

Mr. Michael Kirby: Housing more than anything else. By the way, if you do—I've got to tell you a funny story. Three or four years ago, the federal Minister of Health—I guess it was Tony Clement at the time—asked the government of Nunavut at a meeting, "What would you do if I suddenly came up with \$20 million?" expecting they'd say, "Build a hospital, do whatever"; they said that they'd build housing. That's issue one.

Issue two is, focus entirely on children. The number of children, First Nations and Inuit, who are committing suicide is outrageous. It's important to understand that the second-highest cause of death among Canadians between the ages of 15 and 24 is suicide—and by the way, women are higher than men, which is an interesting observation—and the number for First Nations or Inuit is somewhere between six and seven times the Canadian average. By the way, the Canadian average is third-worst in all of the 27 OECD countries, and yet we don't—let me describe it to you in a way that's pretty dramatic. Every month, the equivalent of a 747 full of Canadian kids crashes. That's the number that are killing themselves. Because they're all done in ones and twos, you don't hear anything about it. So number two, I would focus on kids.

Number three, I would put in place, because of the practical problems of shipping people out for a couple of days, an absolutely first-class telemental health system. I think if you could do that, you could save an awful lot of First Nations children in this country.

Mr. Jeff Leal: Thank you so much.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Senator. Liz?

Mrs. Liz Sandals: Again, I'm focusing on children, so that's good, although the same thing may apply to adult services as well. My observation of children's mental health services in the community is exactly what you have described, which is very fragmented: different communities, different services, different agencies; it's all over the place. Aside from the silos and fragmentation, I guess the thing would be, if you were building a system, what are the services that you actually need from the local community mental health providers in a community? Because my sense is that different communities have different services simply because that's the service that the agency in that community happens to provide. There's no rationale to it.

Mr. Michael Kirby: Yes, that is true. The specific services needed in a particular community: You'd have to ask someone who really knows all the details, but you're quite right.

The historical development of mental health services—and keep in mind, by the way, that more services in mental health are provided by non-health care professionals than are provided by health care professionals. The amount of free labour governments get from family members—you take cases where someone has to quit work in order to look after a child with a mental illness or, in many cases these days, an aging parent who gets dementia and so on. They're quite extraordinary.

The problem on the ground is exactly the way you described it. A need for a service would be recognized—who knows?—a few years ago, decades ago, whatever.

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Mrs. Liz Sandals: Fifteen years ago.

Mr. Michael Kirby: An organization would be formed to deliver the service—and I'm not arguing the service isn't good, but it's so totally fragmented. How anyone with a mental illness or even not a mental illness can find their way through the system is beyond me. Again, I think the picture really works.

You've all heard of the downtown east side of Vancouver, which is supposedly—I guess is—the worst homeless area in the country. There are 400 different private sector agencies, not-for-profits, delivering services on the downtown east side of Vancouver, which is roughly 10 blocks square. By the way, I only know the number because somebody went to the trouble of counting it up. But I would be very surprised, if you went into any sizable city in Ontario—it may not be 400—a comparable kind of province, where people begin a service, do a really good job, and now try to organize it in a manner that is really designed to be focused around the individual with a mental illness rather than the service provider.

The unique part of this business is that it's a service business organized, by and large, for the convenience of the service providers, not for the convenience of the person being served. I ask you to think of any of the other services you take. If you need something done to your house, if you need a plumber or whatever, they actually, believe it or not, try to work to a schedule that works for you, and in a manner that works for you. The mental health system does not work that way on the ground. It's organized absolutely for the convenience of the service providers. That's why changing it is going to be very difficult, but, frankly, it's got to be done. I think that, in the end, our mental health strategy will get machine-gunned by all kinds of people, but that's okay because that will start the debate that will get the change done.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Senator. We've got time for one more question. Helena?

Ms. Helena Jaczek: We had a most instructive visit to CAMH earlier today, and Dr. Goldbloom sends his regards. We understand you go back a very long way.

Mr. Michael Kirby: Forty years. I met him when he was 14.

Ms. Helena Jaczek: I'm really interested in your comment related to early recognition, the front-line, the family physician and the police. One of the things that I

feel would be really valuable for family physicians, in particular, since they're simply put into that position, is some sort of assessment tool. We've heard from parents of children, in particular, saying, "We knew there was something wrong, but we were kind of given the brush-off," and then obviously ending up in a catastrophe and a crisis situation.

In all the work that you've done—we heard a little bit at CAMH about various tools that are out there. I know, having been a family physician, websites don't cut it. The family physician needs something really simple to say, "Yes, I need to refer. This is urgent" or "I can cope with this." I still don't have that sense of comfort that there are tools out there for, as you described them, front-line workers.

Mr. Michael Kirby: You're absolutely correct. We're in the process of doing some work with the—and you can help me because you were a member of the Canadian College of Family Practitioners—is that the—

Ms. Helena Jaczek: Physicians.

Mr. Michael Kirby: Physicians; okay. They absolutely need that tool and it doesn't exist—point one. Point two, there are a number of good self-assessment tools—and I'm hoping we will be able to get them up and running on websites across the country—which at least would allow a parent or an individual to fill out and give you some indication of whether you ought to go for help or not. Because the stigma attached to this issue frequently is such—you would know this as a family doctor—that people will phone up your nurse and say, "I've got a pain in my stomach. I need to come in and see the doctor." When they get in, they will break down and tell you that the real, fundamental problem is that they're depressed, but the stigma is such that they're not even going to tell your nurse that.

The big advantage of an in-home or private initial assessment or screening, if you want, would be extremely helpful. They are two different tools, obviously. The one the doctor wants is different from the other one. But there's an example where technology could play a huge role. The short answer is: We will get you one, but it does not now exist anywhere, to the best of our knowledge. It's not just in Canada; it just doesn't exist.

Some 80% of the people who enter the system or have their first contact with the health care system have it through GPs. These are just round numbers, but the other 20% are because the police have become involved. You can get the exact number for Toronto, but will find, if you talk to a typical big city police chief, that you will be stunned at the percentage of their calls that are mental-health-related. It runs on the order of 50% and up, which is a number that blows your mind. But remember, a lot of the times that they get called on what is a so-called family disturbance is in fact a mental health call. The cause of the family disturbance is that someone's having a psychotic episode in the house. Now, it may get recorded. That's why you have to not just look at the data, you actually have to talk to people like the chief of police and others, who will, in a sense, categorize their

calls differently than they may be categorized by the 911 operator, for example. Anyway, you've identified a dead-on problem that we've got to deal with.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Senator Kirby. Unfortunately, I'm going to have to end it there.

Mr. Michael Kirby: Sorry, I talked too long.

The Chair (Mr. Kevin Daniel Flynn): No, you didn't talk too long; you've just got too many interesting things to say, and we all want to hear about them. Would it be too much to impose on you to ask that you would come back at some point in the fall?

Mr. Michael Kirby: No, let me be very clear: I'm happy to help any of you, either individually or collectively, and so would the staff of the commission. The work you're doing really matters, because in the end, if we're going to deal with the stigma problem and deal with the problem of the need to improve services, that's really—the need to improve services is entirely in your bailiwick. We can explain to you what needs to be done, but we can't do it and we can't fund it.

On the stigma issue, we're going to need a lot of help from you people. We will be launching in the next couple of months an anti-stigma program, for which we are funded for the next 10 years. As time goes on, I'm going to be coming back to you and saying, "How do we get you involved in your local community?" You're leaders in your communities. I need leaders in communities who are going to help me. I would like to find a way to have this whole issue debated on the floor of the Ontario Legislature, because I think that the members of the Legislature—and this has nothing to do with partisanship; it covers everybody. I think people ought to go on record as recognizing that the mental health problem, the stigma issue, has got to be dealt with. One of the ways to do it is, if I go down into Kent county to do an event, to have you with me would be really helpful because it sends a signal.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today. Your attendance was really appreciated.

CANADIAN MENTAL HEALTH ASSOCIATION

The Chair (Mr. Kevin Daniel Flynn): While I call up the Canadian Mental Health Association and ask them to come forward, the question of time allocation for the questions was raised, and the clerk informs me that we still operate on the party system. If at some point you want to change that, we need to get together as a sub-committee. But I think we also need to take into account that we've got eight members on the committee, and generally the presentations are taking on average anywhere from 15 to 20 minutes, which means we'd have eight people splitting 10 minutes. It hasn't been a problem yet, but it may be something that we want to address in the future, just for the equity issue.

But for the time being, that's not of your concern, Mr. Zon and Ms. Gold: You've got 30 minutes. The time is

yours to use any way you see fit. Any time you leave at the end we'll try to split amongst the members as fairly as possible.

Mr. Lorne Zon: Thank you. We'll try and leave as much time as we can at the end. I believe we'll probably leave about half our time for questions.

Before I get to the remarks that I had prepared, there are a couple of things coming out of Senator Kirby's remarks that I just wanted to touch on. One is that I think it's important to realize that the Canadian Mental Health Association focuses on adults for the most part. Although we have worked in schools etc., our focus tends to be on adults, because they obviously are of tremendous interest in children's mental health.

The other is that we share a lot of the interest in mental health promotion, and we will be touching on it today, but Michelle is leading our research in that area and certainly she can add to your knowledge there and answer some of your questions. With that, I'll start.

On behalf of CMHA, Ontario division—we have 33 branches across Ontario—I very much want to thank you for the opportunity to come and speak with you today. My name is Lorne Zon, as you know, and I'm the CEO of CMHA. Michelle, who's with me today, is our senior director of policy and programs and certainly has a wealth of knowledge to bring here.

For those of you who are not familiar with the Canadian Mental Health Association, we're the largest and longest-serving volunteer-led mental health organization in Canada. CMHA is working in every province and in most communities across the country. We have almost 100 years of experience and thousands of volunteers and staff who have been working tirelessly to improve mental health for all. That's one of the things that's different about CMHA than some others: Our focus is on mental health and not a specific mental illness, so that gives us a slightly different perspective.

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In our province, CMHA Ontario has been active for almost 60 years. Our organization undertakes policy analysis and knowledge transfer on mental health and mental illness, utilizing the social determinants of health approach. Our 33 branches, taken together, are the largest providers of community mental health services in the province.

In the short time we have with you today, we have chosen to address a few high-priority issues, and you will see some overlap with what Senator Kirby had to say. We believe that the committee needs to consider and deliberate on the findings and recommendations. When you do that, you need to look at these issues.

It's essential to understand that addressing mental illness is complex, and as such we cannot be successful by choosing simplistic solutions. Effective support for consumers and families requires a holistic and integrated approach to policy, planning and service delivery. For mental illness, unlike many physical illnesses, there is no cure. Instead, we speak of recovery. By recovery, we're talking about maximizing the opportunities for each

individual experiencing a mental illness to live as full and productive a life as possible. In the mental health field, we often speak of three cornerstones of recovery: a home, a friend and a job. Without a place to live, a social support network and enough money to pay for basic necessities, recovery cannot take place.

I'd like to take a couple of moments to highlight some of the very positive innovations happening around Ontario. Firstly, compared to many other provinces, Ontario has in place a more comprehensive basket of services for those living with a serious mental illness. But it is also important to note that comprehensive does not mean balanced, integrated or adequately funded. This is a fundamental point to understand, and certainly Senator Kirby referred to that.

Over the past few years, we have seen two significant investment periods for mental health services totalling some \$227 million. These investments have realized some important outcomes and learnings, which are discussed in the information packages we have brought for you. Certainly the next presenter, Dr. Goering, will be speaking to that as well.

Some of the important innovations in Ontario relate to matching supports to an individual's particular needs. I had the honour of chairing a steering committee that made recommendations to the Ministry of Health and Long-Term Care regarding a new initiative called Ontario common assessment of need. This initiative will lead to a uniform assessment process for every consumer entering the community mental health system. It's very much a partnership between the consumer and the provider and will enhance individualized care planning. As well, Ontario now has a provincial information and referral registry through ConnexOntario, which provides up-to-date, comprehensive information and referral to services across Ontario on a 24/7 basis. At the local level, we are seeing the development of coordinated access to community mental health services. Two models used most frequently are centralized assessment and coordinated joint assessment programs, and these are covered in the material we've left behind for you.

Finally, I'd like to mention the increasing availability of intensive case management, which can improve access to services and system navigation. Intensive case management has been shown to significantly improve housing stabilization, quality of life and reduced hospitalizations for persons with serious mental illness. These positive developments do not mean that the job is done. While progress in service delivery has taken place, there's a substantive level of unmet need.

Since the province has moved to decentralization of the health system, and as a result of the creation of the LHINs, concerns have been raised, which we agree with, that there has been insufficient attention to mental health services and supports from a provincial perspective. In particular, there are major inequities in the funding of community mental health services across the LHINs, a difference of more than 600% in some cases.

As well, we caution that the proposed HBAM model for future funding of the LHINs is not appropriate to

addressing equity issues for community-based services. Also concerning us is the fact that much of the existing funding for community mental health services is no longer protected by provincial policies and can be reallocated by LHINs to other pressure points or priorities within their regions. There's a real risk of service reductions happening in a system that still needs to build capacity.

I'd now like to turn the presentation over to Michelle to discuss some of the priority areas we wish to address.

Ms. Michelle Gold: As you know, a key government priority is reducing emergency room wait times. In the case of patients with a mental illness, emergency room repeat visits are oftentimes the result of hospitals having insufficient information to refer individuals to more appropriate and long-term resources in the community. This has been referred to as a "treat 'em and street 'em" approach. Placing community mental health workers in the emergency room has been shown to effectively divert people to more appropriate community care. Research is demonstrating decreased rates of readmission to hospitals with approaches like this.

We'd also like to mention that emergency rooms are an appropriate point of entry for some people when they are experiencing a psychiatric or medical emergency. People with a mental illness presenting in the emergency room often experience stigma, leading to delays in receiving services, which can, of course, increase wait times. Health professionals need to receive in-service, anti-stigma training to ensure that people with mental health needs are treated with dignity and respect in the ER, to ensure that they receive services in a timely manner.

With regard to primary health care, while many Ontarians with a serious mental illness lack access to primary health care, there are innovative solutions being used in areas across the province.

Family health teams, which include multidisciplinary professionals such as social workers and nurse practitioners, have been shown to significantly enhance both access and delivery of primary health care to people with mental illnesses. However, these teams are still early in their development, and they're only available in select communities of the province.

Having access to primary health care resulted in a 50% reduction in emergency room visits in one Ontario community. These primary health care services were provided by placing a CHC, a community health centre, right in a community mental health agency.

Elsewhere in Ontario, community mental health agencies have partnered, in many cases, with community health centres and family health teams to develop integrated approaches to meet the mental and physical health needs of individuals with a mental illness, but the challenge is that these initiatives are not readily known across sectors and they've not yet found a champion because they cross jurisdictional and funding boundaries.

We would be pleased to arrange for the committee any visits you would be interested in making to see any of these types of programs.

With regard to mental health promotion, I'm sure you've heard the saying, "There's no health without mental health." Mental health is a resource for good health. Everyone experiences mental health somewhere along the continuum, and that's why it's a fundamental requirement for all Ontarians that we need to address.

We know that the key factors that make a difference to positive mental health can be categorized as three key determinants: social inclusion, freedom from discrimination and violence, and access to economic resources.

Mental health promotion policies need to give direction by focusing on individuals, communities and the broader environment in which we live. For example, social and sports programs and arts and cultural activities enhance social inclusion, which in turn generate a sense of community, belonging, social ties and social supports.

Access to economic resources means that people have the education, income, employment and housing to access the essential amenities of life.

Good mental health also leads to productive workplaces, and there are many programs taking place in the workplace. These types of strategies require inter-ministerial and inter-sectoral collaboration that rally together all levels of government, business, non-governmental organizations, community groups and individuals.

There was a question asked about champions. There's a lot known about what promotes mental health. VicHealth in Australia has been at the forefront of evidence-based approaches. CMHA Ontario, with four other provincial organizations—CAMH; Health Nexus, which was formerly called the Ontario Prevention Clearinghouse; the Centre for Health Promotion at the University of Toronto; and the Ontario Public Health Association—have prepared a call to action on what needs to happen for mental health promotion in Ontario.

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Mr. Lorne Zon: In Ontario, we've done many things right. However, we have more work to do to ensure that people living with a mental illness receive the services and supports they need anywhere in the province. We also need to ensure that families and informal caregivers have the support they need to continue to help their loved ones. Senator Kirby talked to that as well. Often we forget how big a part that plays in a person's ability in recovery.

We have work to do to make Ontario a model for our vision at CMHA: mentally healthy people in a healthy society.

We've brought with us an information package that expands on all the issues we've raised and other matters we did not have time to touch upon. We thank you for your time and we're pleased to answer any of your questions.

The Chair (Mr. Kevin Daniel Flynn): Very good.

Mr. Lorne Zon: Perhaps if I could just make one comment before we do that.

The Chair (Mr. Kevin Daniel Flynn): Absolutely.

Mr. Lorne Zon: Michelle talked about going to visit some of our community mental health agencies. I've

been working in health care for almost 35 years and I've seen most systems and been close to most. I've worked at the provincial level, regional level and within a hospital. When I came to this job a couple of years ago, one of the requirements of my job was to go out and visit all of our agencies. I was, frankly, just blown away by what they're doing at these local community mental health agencies, how they have pulled together and worked around all the barriers that we've put in place to actually offer an integrated package of services to people who need them, despite what we've done to get in the way and not necessarily help them. So it would be really interesting for you to do a couple of visits like that, and certainly there are many, many good examples across the province.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much. We've got about 15 minutes left for questions. We'll start with France.

M^{me} France Gélinas: I was taking notes like mad, and I got social inclusion, access to economic resources, and I missed the other one.

Ms. Michelle Gold: It's freedom from discrimination and violence.

M^{me} France Gélinas: Okay.

Ms. Michelle Gold: Within those broad categories are so very many evidence-based strategies that are available—hundreds that are known to impact mental health.

M^{me} France Gélinas: Okay. Thank you.

Mr. Lorne Zon: Perhaps one of the things we can do is make sure that we send you a copy of that paper. You might find it quite interesting that it was done jointly with the others.

M^{me} France Gélinas: Absolutely. I'd love to read it.

Two questions: One has to do with the francophone population of Ontario—a minority no matter where they are. How many of your 22 branches reach out to the francophones of Ontario?

Ms. Michelle Gold: I think it's four of them. They provide bilingual services.

M^{me} France Gélinas: And are there any—here again—best practices or champions that focus specifically on treating francophones with mental illness?

Ms. Michelle Gold: It's not something that we're aware of today, but we could link you up with them and they would be able to answer those questions. Or we could provide you with that information.

M^{me} France Gélinas: And that would be the four CMHAs in Ontario that have bilingual services?

Ms. Michelle Gold: Yes, and they probably would be aware of other resources as well.

M^{me} France Gélinas: Okay. I wanted your point of view as to something that Senator Kirby raised, which is that there is no ministry that deals with mental health. You cut across a series of determinants of health that you've talked about—housing, income etc. Is this a strategy that you studied through your policy analysis? Is this something that you are presently trying to move forward? Or is this an idea that solely rests with the Canadian organization and has not emerged in Ontario?

Ms. Michelle Gold: No, not at all. I think in terms of the broad determinants of health that whole-of-government approaches, where there's a strategy and there is delegation to a number of different ministries, levels of government and others to be accountable and work towards it, are very important.

I think one of the important things to think through is that we're not starting from scratch. Policies in many of your ministries in Ontario can impact mental health, and it's a question of taking inventory of what currently exists, bringing it together within the impact of a strategy that's set out for the province and looking at who can contribute to it. But there needs to be leadership, which is to answer your question that without leadership to drive those changes, it will not be as effective, because everybody is then otherwise working within their own mandate. The mandate needs to be on mental health, to drive through and implement a strategy.

M^{me} France Gélinas: Are you looking at an ADM position for mental health? Are you looking at a ministry of mental health? Have you thought those through?

Mr. Lorne Zon: It's not that simplistic a solution, unfortunately. We have had that route. When I was working in the Ministry of Health, we had an ADM for mental health. We had an entire division focused on mental health, and certainly that helped a lot at that time. We had the big investments into community mental health when we had that division. As Michelle was talking about, it goes beyond a division of the Ministry of Health. It goes beyond the Ministry of Health. It goes beyond even just the social policy field, and it also goes beyond the province, as we heard about. Some of the things we're talking about are within the realm of local municipalities; some are within the realm of the federal government. So it's, how do we get the leadership and champions rather than a position—because I don't think we'll ever get a position. How do we get a coordinated effort and co-ordinated leadership?

One of the reasons we're excited to be here today is because when you look at what's happening in Canada today, and particularly in Ontario, the amount of energy that's being focused on mental health has never been this great. The opportunities are tremendous. But where's the championship and the leadership that's going to be developed out of this to make sure it's sustainable?

M^{me} France Gélinas: My last question has to do with the LHINs. In my riding, lots of mental health providers have come to see me. The LHINs have been so overwhelmed with the ALC crisis in our local hospitals that, frankly, community mental health has not even registered on the radar—read into this, never got a penny more as to their budgets. They haven't even started to talk about an accountability agreement for those agencies—all of their brainpower being on the ALC crisis in hospitals, basically. Is this something that you hear? Is it only the North East LHIN that has this, or are your agencies struggling throughout, since the LHINs have been put into place, to have a little bit of light shine on them?

Mr. Lorne Zon: If there's one thing we've learned, it's that it's a very different situation in every LHIN

because they're starting from a very different place. Certainly, all the community agencies, including all the community mental health agencies, have now signed accountability agreements with the LHIN or else they wouldn't have had their funding after April 1.

I think you're right, the investment this year was minimal. The focus of attention, certainly, is on other provincial priorities. That's the relationship between the LHINs and the provincial government in terms of how they focus their attention. It's something that certainly needs to be worked out, but it's not uniform across the province.

The Chair (Mr. Kevin Daniel Flynn): Liz?

Mrs. Liz Sandals: I was just noticing that one of the papers that you gave us talks about employment supports for persons with mental illness, and I would think that that would be a very difficult area because you're dealing with stigma and having to engage with the broader community. I wonder if you could talk a bit about strategies that you find successful in communities in terms of reintroducing people to employment.

Ms. Michelle Gold: Employment supports is a particular program that's directed for people with serious mental illness to get back to work. Often, it's either a place-and-train model or vocational support before that. It is a challenge, but with the right preparation, people can go on to succeed. Their mental health is better as a result of working. They have more income.

One of the biggest challenges is not getting into the workforce; it's getting access to the programs. The challenge is that employment support programs are funded by multiple ministries. The Ministry of Health funds many of them; some of them are funded by the Ministry of Training, Colleges and Universities; some of them are funded under the Ministry of Community and Social Services for people under ODSP, and there's conflicting eligibility criteria and unintended consequences where people on ODSP might not be eligible for programs. So you have a range of ministries providing funding or supports, but people don't have access.

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The other things is that there are just not enough employment support programs, period. "One size doesn't fit all" is what's often said around employment supports. Different people, depending on the severity of their illness, their previous history, how much education they have—there are different ways to re-enter the workforce or enter for the first time.

There needs to be flexibility, but there needs to be a way where people can access services and the eligibility criteria are aligned so that there's not that chance that people won't be able to access what they need.

Mrs. Liz Sandals: I'm just thinking, for example, then, you might find that a program from TCU is really set up to address unemployment that is due to somebody having been laid off or needing additional education, that to qualify you have to be unemployed because you've been laid off or—

Ms. Michelle Gold: No. The Ministry of Training, Colleges and Universities now has a disability division,

and they are open to suggestions on how to work with people with mental illness. They've also come to the table—some of our staff are involved with this—at a policy level, looking at how to integrate. So there are steps being taken, but it's slow and there needs to be a real review of how to enhance supports to people to get them back to work or to get them to work for the first time.

Mrs. Liz Sandals: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you. Any further questions?

Ms. Sylvia Jones: I wanted to expand on the primary health angle. We've already heard that 80% who are accessing services have that first connection with their family physician. I'm familiar with family health teams in my community that have the position of a mental health worker but are unable to fill it. I wonder if you have some examples from your agencies of where there are some successful collaborations, and sort of give an overview of what those collaborations look like.

Ms. Michelle Gold: There are a lot of community mental health agencies interested in collaborating with primary health care providers, and one of the ways that's taking place now is that in some cases community mental health providers are supervising staff in family health teams. Another way is that they're actually co-locating. The primary care provider will provide the medical care and the medication prescriptions, and the community mental health worker will take on other elements like housing, employment and those types of things. The response we have is that these things are working very well, that there needs to be a concerted approach that's comprehensive. These types of things are happening. At other times, there are secondments, where a community mental health worker will go in.

Community mental health agencies were set up to deal with people with serious mental illness, so that's one element. The other part is people with mild to moderate mental illness, and they sometimes fall through the cracks. This is something we're hearing a lot from the community mental health agencies. As Mr. Kirby said, they're sort of caught betwixt and between. They're not eligible for community mental health agency services; they don't have a serious mental illness, and there's sometimes a hesitancy by primary care providers to provide services. Even if primary health providers can screen for mild to moderate mental illness—and anxiety and depression are very common—the screening will not be impactful unless there's the self-efficacy so the provider feels confident that they can then treat people with depression and anxiety. That's another place where there are many things going on but still more needs to happen.

There are shared-care models going on where family physicians are linking up with psychiatrists. This has been going on for about 10 years. There are very many models. It depends on the needs of the patient, but even before that, even access to care.

Ms. Sylvia Jones: Do you find that those co-location models are working, are successful—because you're dealing with the stigma issue as well—that you're not

ending up with that you have to be in that critical state and therefore be referred?

Mr. Lorne Zon: I think there are a couple things, if I can just comment and sort of take a different angle from what Michelle was doing.

You talk about the position of a community mental health worker within a family health team, and certainly that's an enhancement to what we might have had in a solo practitioner's office or in a more traditional primary care model. But the kind of things that Michelle's talking about—and it's outlined in one of the Network magazines that's in your package—is that when you partner with another agency, you're avoiding building another silo. I mean, even if you have an excellent community mental health worker on your family health team, it's still within that. If you work in partnership with a community mental health agency, they also have the opportunity to access the other range of supports that individual is going to need. So I think it's a better enhancement to the primary care model than just the position, and we do talk about some of the interesting innovations in that and in one of the things in your package. If there's an interest, we can follow up and perhaps even arrange a site visit for you if you'd like to see how that works.

Ms. Sylvia Jones: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Lorne and Michelle. Your time was certainly well-spent and appreciated. Thank you very much and thanks for the package. I glanced through the magazines; they look pretty interesting and they look like an easy read. Even I could understand them.

PAULA GOERING

The Chair (Mr. Kevin Daniel Flynn): Our next speaker today is Dr. Paula Goering. Professor Goering is associated with U of T and CAMH. She's a project lead with the Mental Health Commission of Canada.

Dr. Paula Goering: Hello, everyone.

The Chair (Mr. Kevin Daniel Flynn): Hello. As with everybody else, you have 30 minutes. You can use that any way you see fit, but the committee probably would like some time near the end to ask you some questions, if that's okay with you.

Dr. Paula Goering: I would much prefer to answer your questions than to tell you things you're not interested in, so I'll keep my remarks very brief.

I first just wanted to tell you that it's very nice to be here, and it's quite exciting for me to see the level of interest that we have right now about mental health and addictions. I've been around for a long time. You were at CAMH today; I started out as a nurse in the old asylum; that was my first job. I watched those towers that you saw today being built and that are now being declared decrepit and torn down, which gives you some indication of how long I've been around. In that entire career, which is a fairly long one, I have never been as excited as I am about the opportunities that we have in front of us. I'm sitting on the minister's advisory committee, I'm

working very closely with the Mental Health Commission, and it just feels like our time has finally come and that you will be helping us to accomplish things that we've been wanting to do for a very long time.

But I'm coming here mostly as a researcher. That's what I've spent most of my career doing, doing research and consulting and working very closely with government. So my kind of high-level message for you is to remind you that research and evaluation are really important tools for you. For you to be able to do what you've set out, which is very ambitious, you will be doing lots of consultation, you'll be hearing lots of very important first-person stories, but you also need to know that there's lots of knowledge and information there that can be of help to you in figuring out how to solve the problems you'll be uncovering.

I'm going to just give you a couple of examples to convince you, if you're not already convinced. I see a lot of head-nodding; that's nice, but sometimes this is a hard sell. I want to talk to you about one study that's just winding up and another study that's just getting under way, to give you a sense of what I'm talking about and hopefully to whet your appetite so then you'll want to read more and know more than I can possibly tell you in the time we've got together this evening.

The study that's winding up is the one that is being circulated with the bright orange cover. Actually, it's hot off the press. We just got this from the publisher yesterday, so it was nice that we got them in time that we could give you one. These are the results of a four-year, \$2-million evaluation effort that your government funded and that a lot of different universities and community mental health agencies were involved in actually carrying out. It was an evaluation of what happened when a lot of new money was put into community mental health.

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In 2004 we had a significant expansion of the resources in community mental health, both because of the accord funding and because of the human service and justice funding that went into the system. This amounted to about an additional \$165 million, and that was about a 50% increase in the base operating budget of that sector of our system. That was quite extraordinary. Your government decided to not only put the new money in the system but also put money into evaluating and seeing what happens when you put new money into the system.

That is unusual. Policy does not oftentimes get evaluated, and I think as politicians you should be aware of how important it is, not just to make decisions and allocations but then to follow up and see whether it works the way in which you intended it to work. That's what we got a chance to do and the report is a summary of the nine different studies that were done over the three or four years to look at different aspects of what happened in the system.

I'm just going to give you one example of a difficult problem that I think that study helped point the solution to, and that is the problem of the increasing numbers of individuals who have mental illness and addiction who

end up in our criminal justice system. The issue of legal involvement and the number of people who, because they're not getting adequate supports, end up being arrested or charged or sometimes imprisoned is a huge one, and yet if you look at the literature and you look at some of the studies we've done in Ontario, there are solutions to that.

We know how to provide court support programs that are particularly targeted to individuals who've been arrested or are appearing before the courts and get them into the mental health system, which is where they belong, rather than leaving them to be treated as if they were criminals without a significant disabling mental illness.

One of the court support program evaluations was done in Ottawa. Tim Aubry was the principal investigator. He followed 120 people who had been treated in a few years and the findings about those individuals and what happened to them were very encouraging. They had less homelessness. They had fewer symptoms. They were more integrated into their community. So a lot of very positive findings not only for the individuals but also for the courts and the justice system—very pleased with this program because it helps them deal with what for them is also a difficult problem.

So there's part of the solution, but when you look at the other findings that we had—one other study looked at several court support programs across the province—what we found there was a bit more disturbing in that people had, over time, less continuity of care. What that means is that it was getting harder and harder for the programs to actually refer people and get the services they need, which kinds of makes sense, doesn't it? If you put money into one part of the system, it can create demands in the other parts of the system. That's what's happened and that's what we're observing.

The thing you need to think about when you're trying to think about problems and their solutions is that you have to be careful about targeting single programs and not thinking in terms of systems and the effect on the system of care. Also, whatever you're doing, you need to add in the idea that it needs to be monitored to make sure that it's actually doing what it's intended to do.

That's an example from that study. There's a lot more in that report and there are lots of reports on the website from the various studies.

The other example I want to talk about is one from the demonstration model on homelessness and mental illness that—I came in late. I don't know if Mike Kirby referred to it. It's the Mental Health Commission study that's being done across the country.

Interjection.

Dr. Paula Goering: He didn't talk about it? Okay.

This is extraordinary. It's a very important part of what the commission is doing as a catalyst across the country to help us learn and do things. They actually got the federal government to allocate \$110 million for a demonstration project in five cities in Canada. I'm acting as the lead researcher in that project, and Jayne Barker,

who is the policy and research director in the commission, is the lead within the commission. We're under way trying to put in place services, rent supplements and housing in these cities, and study it at the same time. That size of research project is quite unusual, and our ability to do something at the same time we're learning something, so that we'll actually be serving individuals while we're studying them, is very exciting.

One of the cities is Toronto, so Ontario has one of the sites, and there are very interesting things that are going to be learned here. In particular, they're looking at developing an innovative ethnocultural approach to providing housing and services for the homeless. But you're also going to be interested, I hope, in what we're learning in the other cities. We're very pleased to be in Moncton; everybody always asks, "Why are you in Moncton?" because we're in Vancouver, Montreal, Winnipeg and Toronto. But actually, there are a lot of mid-sized and rural areas in Ontario which have problems with homelessness, and our evidence base there is extremely weak. So we're really pleased that we're also getting a chance to learn about how to deliver services in that size a city.

This is a four-year project, and you may be thinking, "Well, what has that evidence got to do with what you're going to be doing over the next year?" I would say to you that it's an example of where research can help you learn what works. But without political will, without public policy, it will be of very little value to know what works, because we won't be doing what works. Thinking now about homelessness, and the intergovernmental action plan, the consortium, that takes seriously the fact that we could end homelessness, we could. If we did it together and did what we know works, we could tackle the problem. It's an example of where research can be one of the tools, but without people picking it up and using it and doing other things with it, it will be limited in its value.

I'm going to stop there and hope you have questions or comments.

The Chair (Mr. Kevin Daniel Flynn): Thank you. We certainly do, starting with Helena.

Ms. Helena Jaczek: Thank you, Dr. Goering. I couldn't agree more with you on the value of evaluation of programs and obviously wanting to get solutions, instances of programs that work. I'm just quickly glancing through, and on page 7 you've got some very concrete examples of specific programs that have been assessed and seem to be having positive outcomes.

My colleague Madame Gélinas is very interested in health promotion, as am I. Can you give us any examples of mental health promotion programs that work, above and beyond physical activity and eating well, which was one example that we were given today at CAMH?

Dr. Paula Goering: Yes. I think that we have a much broader range of programs for you to look at. If you look at one close at hand, at CAMH, which has been very well researched, you would look at the anti-bullying program that Dr. David Wolfe has been involved in, in terms of developing and putting into schools. There's an example

of a kind of intervention that has been studied and makes sense; if you can help individuals at a young age to learn how to be more civil and how to protect themselves when others are abusive or attacking, that will assist us in them developing longer-term solutions. That would be just an example.

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Ms. Helena Jaczek: So you're saying this is a program that is delivered to all kids, it's sort of a population health-based initiative and there has been some sort of randomized, controlled study that compares those who have received the program with those who have not, and as we follow them over time, we see different outcomes?

Dr. Paula Goering: Yes. To be honest with you, health promotion is not my area of expertise and I'm not entirely sure of the design of the David Wolfe studies, but I'm pretty sure that they're trials. I can check on that and let you know.

Ms. Helena Jaczek: I'd be really interested—

Interjection.

Dr. Paula Goering: I know they're very solid and well researched, but I'm not sure what the design was.

The Chair (Mr. Kevin Daniel Flynn): I had a question myself, just from the Chair: How much of the existing system we have today is process-based and how much of it is outcome-based? Do we pat ourselves on the back because we saw 30 people today or do we celebrate that we made six people well?

Dr. Paula Goering: Well, one of the things that gets in the way of being outcome-based is that our information system is about outcomes. It is something you do need to be attending to. It's not just a matter of needing to fund research and evaluation; we also have to have the data in order to do the research and evaluation. Often-times, it's not available to us and not available in easily accessible forms.

That being said, I think on the whole there is a great interest in quality of life, housing stability, employment and reducing disability at work as being the things that people most want to see happen. It's our ability to track that and account for that in our day-to-day work that I think is more problematic. It's not that people don't care about the outcomes; it's just that it's harder to see them and see them as a direct relationship to what is being provided in the service. Quality of life, for example, is a major concept, and what we do in a treatment program is only a small part of the picture. What we do as a society about housing, income and jobs probably has a far greater impact on people's quality of life than the health care piece of it.

The Chair (Mr. Kevin Daniel Flynn): Thank you. There's time for one more short question from the government side. Anybody? If not, we'll just move on to Sylvia.

Ms. Sylvia Jones: I'm interested in—as your studies and your research move forward, are they going to be accessible to all levels of government? I understand that the feds have funded the 10-year project. Is that right?

Dr. Paula Goering: I'm sorry, I didn't hear the last phrase.

Ms. Sylvia Jones: The feds—the federal government—has funded you now. So as your research moves forward and you bring forward these reports, are you—

Dr. Paula Goering: No. The homeless project is being conducted as what we call “integrated knowledge translation,” which means we don't wait until the end to start talking to the partners. In fact, we've got all levels of government talking to us about how to do the research, how to design the intervention and what do we make of the findings. So it will be very interactive.

There was a meeting in Toronto on Tuesday in which the city, the province and the LHINs were a part of the discussion about the launching of the Toronto site. Very much, we want to keep the conversation going because we don't think it makes sense to go away, do a federal study and at the end of it, come back with the findings, hand them over and say, “Okay. Now what are you going to do?” That doesn't make sense.

Ms. Sylvia Jones: As you're discussing how you're going to study, do you get into the kind of detail of length of stay? I know, for example, the federal homelessness money—right now, it's a very limited window of how long a young person is able to stay in a homelessness shelter before they have to flip over, before the funding stops. Is there any discussion going on—

Dr. Paula Goering: Not that I know of at this point, and it wouldn't be a direct discussion about this project because it's about how to get people out of shelters and into homes and into society. But there will be opportunities around this project for other issues to arise and be dealt with around how the system is operating, because we're encouraging the groups who meet to think about their responsibilities for systems issues and integration, not just think about the project per se. So it could be an issue, but I don't know that it has been.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Sylvia. France?

M^{me} France Gélinas: I'd like to try my question of leadership on you as well to see what you think of it, basically either through the lens of a researcher or whatever vast experience you have in the field of mental health. We've heard the first two presenters talk about the issue that there isn't a point of leadership within the provincial government for mental health. Mental health goes across housing, income support, health and a vast array of other silos of government. Has any thought been given as to what this leadership to bring mental health forward should look like, how it should be structured, nurtured? Are there best practices out there that exist? Do you know anything about that, basically?

Dr. Paula Goering: Yes, I've spent a lot of my career thinking about that and at various points of time putting forth ideas that could be considered about how to deal with it. I have to acknowledge, though, that this is an area where you don't have good research evidence. It's very hard to study and compare different models of governance and leadership at a systems level. So what we learn is mostly by looking at jurisdictions that seem to be working really well and comparing them to other juris-

dictions and trying to kind of distil out the component. We did that about 15 years ago in a best practices document that we did for Health Canada, where we reviewed all the literature and the other jurisdictions, and in our section on governance we said that we need a single point of accountability at a high level in government in order for us to move forward in the area.

At various points in time we have discussed in this province having regional mental health authorities that would have the responsibility for the mental health system, as opposed to being integrated into a regional health system, so it's the question of separating out and doing it. It has never had much traction, and people are quite concerned when you talk about it that what you lose there in terms of the connection with primary care and the rest of health care is the liability. So I'd say there was controversy about that. If you asked me my personal feeling about it, I would say we would be better off with mental health authorities and we'd be better off with an ADM for mental health.

M^{me} France Gélinas: Okay. My next question—do I still have time?—will have to do with the LHINs, local health integration networks. I realize you talked about mental health regionalization. Do you figure that having the community-based mental health agency under the LHINs—is this something that we can build on? Is this the right direction to go? Are there ideas there, best practice, or are we having a tougher time because of it?

Dr. Paula Goering: The concern is that when mental health is put in with everything else, as it is in the regional authorities, it gets lower down on the priorities, that it won't be able to compete with acute care and with cancer care and with a lot of the other priorities that are higher in the public's mind in terms of where we should be investing our resources for mental health and addiction. So that's the worry.

So far, in Ontario, because of very active advocacy on the part of provincial organizations, and on the part of patient and family groups, mental health is on the LHINs' agenda, so it continues to be a priority. The question is, what does it mean that it's a priority, and will it be translated into allocations and protection and expansion of an under-resourced sector? I don't think we have the answer to that yet, in our current LHIN environment.

M^{me} France Gélinas: Thank you.

The Chair (Mr. Kevin Daniel Flynn): I have a question that I keep asking: Are we seeing an increased incidence of mental health issues? Are we talking about it more? Do we understand it more and do we recognize it more? And in particular, the knowledge I seem to be getting back is that it was always there and we just recognize it more. Are we seeing an increase, though, in teen suicides, and are we seeing an increase in addictions?

Dr. Paula Goering: I don't think that we can say that there's a trend over time for a higher prevalence rate. I think it is more visible and it is more acknowledged.

The one place for which I might qualify that is with regard to young people. We've done a couple of epi-

demiological surveys. Years ago, we did the Ontario mental health supplement, and we were very surprised at that time to see that the highest rates of mental health and addiction problems were in 16- to 24-year-olds. That was the window we had on young people.

I was involved in the national community mental health survey across the country, which was released two or three years ago—again, very high rates in that young group, which I find very perturbing in terms of thinking about what that means for the future. I think that's a new phenomenon. To go back and try to test that would be somewhat difficult, because in the surveys, people don't always define in the same ways what we're looking at. But we were surprised at it in the supplement, and when we saw it again across the country, in the national epidemiological survey, it caused me great alarm.

The other problem there is, they don't go for help. So they have both higher prevalence rates and they're less likely to at least tell us that they're getting services or getting help.

There are so many subgroups—people who are on the street, young people. We should be very worried about, and thinking about—surely we can do a better job than what we're doing.

The Chair (Mr. Kevin Daniel Flynn): And on suicide and addictions, are we starting to call suicide what it is? Have we stopped using the code words, and are people starting to address it? Has it always been there, or are you seeing an increase?

Dr. Paula Goering: You know, I'm a bit hesitant to give you the answers without going back and checking the data, and I'm sure we have it. My recall is that in Quebec, we've seen increasing rates, but not in the other provinces over time. But I need to check that, in order to give you an honest answer about it.

I do think we're being more open about it, and even in obituaries, you are sometimes seeing people acknowledging that someone has taken their life, and that can be said publicly. You wouldn't have seen that 20 years ago.

But the rates that are based on the administrative data and the reporting of suicide—I don't think we've seen a significant increase in Ontario.

The Chair (Mr. Kevin Daniel Flynn): Okay. And is there an increase in addictions, in your opinion, or just a change in substances?

Dr. Paula Goering: Addictions is such a big field, in terms of all the different things underneath it, including alcohol. And it's not my area of expertise, so I'm not going to try to answer that question. But I can get back to you about it, because my colleagues can answer it, so I'll let you know.

The Chair (Mr. Kevin Daniel Flynn): I think we'd all be interested in that answer.

Dr. Paula Goering: Okay.

The Chair (Mr. Kevin Daniel Flynn): France, for the last question.

M^{me} France Gélinas: Just very, very quickly: You made reference to a study you did 15 years ago. You had a chapter on governance. If we were to try to track it

down, can you give us some hints as to—do you remember the title?

Dr. Paula Goering: It's called Best Practices in Mental Health Reform. It was published by Health Canada, but the easiest way of getting that is to come to me and I'll get it to you.

M^{me} France Gélinas: Okay.

Mrs. Liz Sandals: Could you get a copy for the committee?

The Chair (Mr. Kevin Daniel Flynn): I think we'd all like one of those.

Dr. Paula Goering: Okay. Well, you should also know that as part of the minister's advisory committee work, the government has commissioned us to do some updating, because that document is quite old. So we're working with them now, and I'm hoping that the kind of materials that the advisory committee is getting, you'll also be interested in and have access to. I don't know

how that's going to work. Maybe you should hold off and get the newer version.

The Chair (Mr. Kevin Daniel Flynn): Okay. Well, thank you, Dr. Goering. We really appreciate your time and the information you gave us today. Thank you for appearing.

Dr. Paula Goering: Glad to be here.

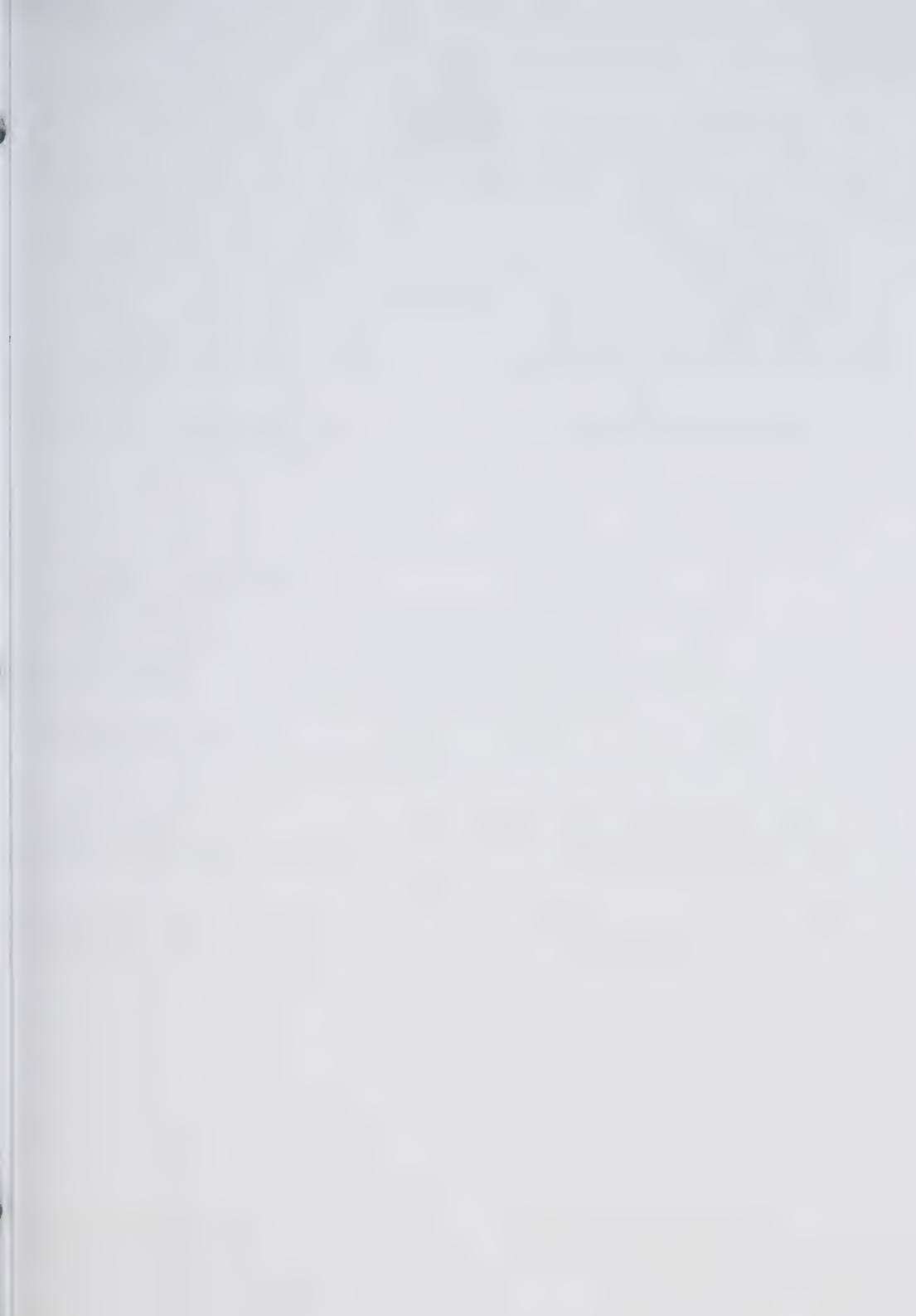
The Chair (Mr. Kevin Daniel Flynn): Thank you, members. Our next meeting is next Wednesday, and just a forewarning: It's a long one. It goes—

Mrs. Liz Sandals: So we start at 4?

The Chair (Mr. Kevin Daniel Flynn): I guess we start at 4 and we'll probably go till 7, by the sounds of it, just so everybody can plan their schedule a little bit.

As well, thank you very much to all those members of the audience who attended today.

The committee adjourned at 1842.



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MH-9

ISSN 1918-9613

Legislative Assembly of Ontario

First Session, 39th Parliament

Assemblée législative de l'Ontario

Première session, 39^e législature

Official Report of Debates (Hansard)

Wednesday 3 June 2009

Journal des débats (Hansard)

Mercredi 3 juin 2009

Select Committee on Mental Health and Addictions

**Mental health and addictions
strategy**

Comité spécial de la santé mentale et des dépendances

**Stratégie sur la santé mentale et
les dépendances**

Chair: Kevin Daniel Flynn
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LEGISLATIVE ASSEMBLY OF ONTARIO

SELECT COMMITTEE ON
MENTAL HEALTH AND ADDICTIONS

Wednesday 3 June 2009

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ SPÉCIAL DE LA SANTÉ
MENTALE ET DES DÉPENDANCES

Mercredi 3 juin 2009

*The committee met at 1604 in committee room 1.*MENTAL HEALTH AND ADDICTIONS
STRATEGY

The Chair (Mr. Kevin Daniel Flynn): Okay, if we can call to order. We've got a few members who are joining us in progress. The House is still proceeding through its routine proceedings, and there are some tributes and speeches being made as we near the end of the session. We are going to get going, as we do have a pretty tough agenda ahead of us. It will have us here until at least 7 o'clock, by the looks of it.

MINISTRY OF EDUCATION

The Chair (Mr. Kevin Daniel Flynn): Let me introduce the first delegation; it's from the Ministry of Education. We've got Grant Clarke, who is the acting assistant deputy minister, and Barry Finlay, who is director of special education, policy and programs branch. Each delegation is being given 30 minutes, and you can use that as you see fit, but the trend has been to leave a little bit of time at the end for some questions and answers, we hope. Having said that, the floor is yours and welcome.

Mr. Grant Clarke: Thank you very much. I'm Grant Clarke, and this is my colleague Barry Finlay. Our plan would be to maybe walk quite quickly through the presentation, about 15 or 20 minutes, and have 10 or 15 minutes at the end for any questions the committee members may have.

I'll lead off. You have a package in front of you which is a synopsis of a number of key initiatives that the Ministry of Education is involved with and also points to some of our collaborative work with our colleagues in the Ministry of Children and Youth Services. We're going to walk through it. I'll start by setting the context for it and then ask Barry to carry through on the substance of the deck. We won't read the deck, but we'll just highlight for you, on each of the pages, the key points. If there is anything you'd like to come back to, by all means, we'll be happy to provide you with additional detail.

The stats slide on page 2 probably is familiar to the committee members at this point. Then there are a couple of slides, 3 and 4, which were just background information on the size and scope of public education in Ontario—over two million students and 5,000 schools,

4,000 of which are elementary, 800 and so on are secondary, a very large system—and some details on recent funding, including the last funding increases for the coming year of 2009-10.

If we could go to slide 5, I think this is where the narrative for us would begin. To set the context, Ontario does have three strategic goals for education, and they're listed on the left-hand side of that slide: higher levels of student achievement—and I might also say student well-being is included within that notion; reduced gaps in student achievement, which includes ensuring outcomes for students who are either English-language learners in the province or students with special needs—in some instances boys, with respect to literacy, as we know, continue to be a pressing concern—that we are able to work successfully with our partners in education to close their achievement gaps, to ensure that the gap between students who are performing at the highest levels in the province and those who are performing at the lowest levels decreases over time.

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The third goal is increased public confidence in publicly funded education in Ontario.

Related to that, our student success agenda can be characterized by those three goals. Certainly, special education programs and services are within the framework of student success, an integral part of it, in fact, and the means by which the ministry, in collaboration with school boards and partner groups, attempts to provide those appropriate supports and services to groups of students.

Improved student outcomes for students receiving special education is parallel, of course, to our goal of higher levels of student achievement and well-being for all students.

Building the capacity of schools to effectively meet the diversity of learner needs: We're doing that through a number of targeted initiatives.

Next is ensuring that students who have individual education plans—that's what IEP stands for—which set out for them the program of studies and supports that they will receive through special education programming and supports, that that's linked to curriculum expectations and to progress of those students through the school system so that they have a very solid chance of achieving their educational goals.

Next is more collaboration and co-operation among schools and sectors, including, of course, families and

their advocates who are facing learning challenges in the system, recognizing that it is a shared responsibility and that better outcomes can be assured by working in a collaborative manner.

Last is focusing on the balance between teaching and learning, including providing the appropriate documentation, but first and foremost providing, in a responsive way, supports, programs and services for those students who have special learning needs.

That's the context within which much of what follows in the deck is positioned. I'm going to ask Barry now to walk you through the remaining portions of the deck.

Mr. Barry Finlay: Thank you, Grant.

I need to start with a story to provide a context for our supports for children with mental health needs. It provides a context, I believe, for what we do in public education in support of building healthy young individuals.

I'll take you back to a field, and a family where the father, who is a subsistence farmer, engages all of his children annually in the growing of his crops, in order for the family to survive. He starts by taking his youngest children out each year, and he has them plant a seed. Then he encourages them to nurture, water and take care of that seed and its growth.

This particular father did this with his three-year-old daughter. He did that, and she went out and planted the seed and did everything he asked her to do.

They went back the second year and in fact there had been no growth. The young girl was very upset, thinking that she hadn't done something properly. And he said, "Be patient, my child. If you continue to water your seed and take care of it and feed it and do everything that you should be doing, it will be fine." And she did this the second year. The little girl once again came back and was more distraught because it had only grown an inch. But because she was a little girl and still listened to what her father had to say, she continued to water it and take care of it.

The third year, the same thing happened. At this point, she became very frustrated.

But in the fourth year, finally, she came back and it had grown 60 feet.

In fact, what they were planting was Chinese bamboo. The first four years of growth for Chinese bamboo is all underground. It builds the huge web of its root system in order to support the rapid growth in future years.

For all intents and purposes, that's what we do in public education and in support of children with mental health needs. Our focus is on that universal support and early programming for kids, to help build well-being.

We'll talk about a continuum of service for our children, but you'll see that many of our actions now in our schools are dedicated to that healthy growth and development of our young children, and then, where necessary, attempting to get additional services in order to support children's mental health needs. I would also say that critical about that is the fact that it's about an individual seed, and we are very much focused now, at a provincial level, on all children and each individual child

and moving to support individual children, as you will see.

On page 6, you will see a bit of a summary of an approach that we'll be taking in schools in terms of supporting kids' needs. Once, in fact, individuals identify that there are some challenges—they didn't make referrals—if in fact they can do it internally, then they provide the supports. If they can't, then they will attempt to access supports for children outside the education system.

One of the challenges that you will see as we go forward is that children's mental health is really not an identified exceptionality in terms of special education. We have 12 exceptionalities in special education, within four broad categories, and at any given time, children's mental health needs may affect any or all of the children who fall within those exceptionalities. So it's part of the challenge that we all face, consistent with Senator Kirby's treatise of trying to get this out of the shadows.

On page 8, we have a definition for support for children with emotional and behavioural needs—but it's not really about children's mental health. Once again, it's still part of the challenge that we face, but it is one of the exceptionalities. I will point out to you that presently in Saskatchewan and in British Columbia, they have moved to the identification of children's mental health needs as an exceptionality under special education. We have not moved to that at this point, and continue to support the non-medicalization of our exceptionalities and focus it upon learning.

We presently serve approximately 290,000 students in the province with special education needs. Approximately two thirds of those are identified formally through an identification placement review committee process. Therefore, there is a formal placement and identification that does take place. Approximately one third are not officially identified but still receive special education programs and services.

On page 11, we do have in place, and have had for a few years, care and treatment programs to serve children's mental health needs. The focus for these programs is, in fact, treatment. We provide an educational resource—teachers to the program—but these programs are housed, for the most part, in agencies separate from district school boards, and the education is secondary to the treatment, the whole goal being the transition, to get them back into the school system as soon as we possibly can.

As I indicated, our primary focus is around universal and preventive programming for children. Through our health and physical education programs from grade 1 right through to grade 12, building positive children's mental health is addressed, but also, as you will see, are issues such as substance use and abuse, personal safety, injury prevention, healthy growth and development etc. Even in our social science and humanities curriculum in the senior years, there are programs that do address children's mental health issues.

In addition, I would say, having come from the system for many years, schools and boards have a number of

programs that they offer in support of children's mental health needs and building children's wellness. One that we have facilitated at a ministry level, in co-operation with the Ministry of Health, is the healthy schools recognition program, and that's on page 13.

I already addressed some of the curriculum references, but they are very specific for you there on page 14.

We are working with the Ministry of Children and Youth Services around a mapping process. I know that they are presenting at 5 o'clock today, so they will go into more detail with respect to this process, but the purpose of this is for the mapping of all the children's mental health agencies and supports in the province, in co-operation with education, so that we identify not only the resources that are provided through education, but those that we are doing in a collaborative way between and among agencies in communities. We're just moving to phase 2 of that mapping process, which, in fact, will identify the costs related to all of these programs so that we can ensure that we're optimizing the benefit of those programs.

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A program that has not been very costly but has been quite effective is the student support leadership initiative, which is a joint initiative between the Ministry of Education and the Ministry of Children and Youth Services. It's focused upon building collaborative supports within boards and within communities in support of children's mental health needs. They're moving to the third year of that program, where they will be identifying how they will be sustaining the relationships that they've already established and hopefully perpetuating some of the additional resources for students.

We have also entered into some research work, on page 18, supporting the Provincial Centre of Excellence for Child and Youth Mental Health out of the Children's Hospital of Eastern Ontario. Once again, the focus of that research is not only an extensive literature search, but also identifying effective practices of collaboration between boards and health and social service agencies in support of children's needs. Education itself is working with a consultant to do a similar project with respect to the focus on collaboration.

Within that context, the preliminary findings from our external consultant identified some factors that contribute to successful collaboration, and you'll see those on page 18. Not surprisingly, the building of trusting relationships among everyone involved is critical to us going forward in this initiative. Also, factors that serve as barriers to successful collaboration have also been articulated. Often, if we can go at those barriers, the enablers come forward when we remove the barriers to being successful.

The potential framework that has been identified through this research work is not surprising. It identifies a need for some provincial coordination and some work among our ministries to coordinate, and I would say to go beyond that and continue to collaborate in support of children's mental health needs. But we also need it to be addressed at every level: at the district level, to have

planning tables doing the same thing; and then at the local level, even between schools, local agencies and within communities, in order to optimize the supports that we presently have in place for students.

In summary, we've always had students in our boards and in our schools with children's mental health needs. We do have roles in our boards to support this. We have psychologists, we have social workers, we have child and youth workers etc. Having said that, we just completed, over the last year and a half, a fairly comprehensive program and financial reviews of 11 district school boards in the province. That included interviews with parents and with staff members representing all roles—directors etc. Among all of those boards and in all of those discussions, children's mental health always came out within the top two in terms of their challenges.

So the issues that we face are not insignificant and they're being felt everywhere. I would say that at a personal level, I'm very pleased that you're convening these meetings because it's an area where our boards are certainly saying, "We really need some additional support and some help."

Thank you, and I'll be happy to answer any questions.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much. I think our practice in the past has always been to start to my left, so I'm going to alternate today and start to our right for this delegation.

Ms. Sylvia Jones: Why change now?

The Chair (Mr. Kevin Daniel Flynn): Well, I'm just trying to be fair. I know there was a question raised the other time, so I'm sensitive to the questions, but I think we can get through it as a committee. Why don't we start with Jeff and then go to France, and then go to Christine or Sylvia. Jeff?

Mr. Jeff Leal: I'd just like to add a question for Mr. Finlay. Thank you for your presentation. And I'll put my preamble: My wife happens to be a vice-principal in a school in Peterborough.

I remember reading the report from Dr. Fraser Mustard and Margaret McCain. One of the things of this government, as an early initiative, was to reduce class sizes in the primary classes. Do we have data now within the ministry to indicate that the reduction of class sizes in the primary classes—one of the reasons that was suggested was to identify potential problems in children earlier and look for solutions early on in their education experience to provide a better platform as they move into the intermediate and on to the senior grades. Have we looked at that and have we got data to indicate what's transpired since we've implemented the lower class sizes?

Mr. Barry Finlay: I'm not aware of any specific data related to that. What I am aware of are the continuous improvements of our EQAO results as a result of the earlier identification, especially in the area of literacy and the growth that has taken place over the past few years. What I would say is that during this past year we had significant growth for children with special education needs, those who are receiving special education pro-

grams and services, at both grade 3 and grade 6. We attribute much of that growth to earlier intervention and supports. Once again, many of those children in those early years are not yet identified, but they are receiving special education programs and services as we work with them to determine whether in fact they have a specific learning problem.

Mr. Jeff Leal: Mr. Finlay, presumably that would also be of great value if there's a debate around today whether we go to full-time kindergarten or not—even earlier identification.

Mr. Barry Finlay: I would certainly support that, and I think for those of us who have been in the system for a long time, the earlier the better.

Mr. Jeff Leal: Thank you, sir.

The Chair (Mr. Kevin Daniel Flynn): Let's go to France and then Christine or Sylvia and then come back to this side.

M^{me} France Gélinas: Thank you, Mr. Finlay and Mr. Clarke, for coming here. We heard from other deputants the idea that maybe we don't do enough early identification of children with mental health needs. I liked one of your opening comments, that you certainly do not have the skills to identify mental illness; I mean, you do education and not mental health. But has any thought been given at all to some kind of a screening that would happen, let's say, in grade 3 and in grade 7, and we go through all of the kids and screen them for mental health and mental illness or mental health needs? Is this something that has ever been talked about at your board or at the ministry?

Mr. Barry Finlay: Not to my knowledge, with respect to a specific screening at those levels for this particular need. I think one of our challenges, as you indicated, is the level of expertise that we have in terms of identifying mental health needs. Very clearly, in education, we attempt to maintain our own level of expertise. Therefore, our focus is primarily on building positive mental health, and then when we get to a level where we need to engage someone else, we do that. A number of boards have psychologists, and they would employ psychologists for that purpose and identify them through a similar process as the IPRC process, with identified specific need, and then they would do assessments. Right now, it is not universal; it is individual, based upon identifying individual needs.

Mr. Grant Clarke: One of the focuses the ministry does have, and many school boards are involved with, is kind of an early identification of readiness for learning, if you will, using a number of indices. There's one out of the Offord Centre—the EDI, is it?

Mr. Barry Finlay: Yes.

Mr. Grant Clarke: It's looking at, as young people come into the system, what their capacity is to really learn within the classroom. It's not the same as an assessment for a specific purpose—mental health and other—but often there is an overlap or collaboration where one set of indicators may alert you to the need for further assessment.

We also had a multi-year study—and perhaps Barry can tell you a little bit more about that—with the Ontario Psychological Association looking at early assessment from the standpoint of reducing the amount of time or lag between a problem with a child and a referral, if that was needed, or some other remedy that was within the scope of what teachers in the classrooms could actually do to mitigate the need for subsequent referrals. So we're operating on a number of fronts. I think you could probably anticipate that we will, with the release of Dr. Pascal's report and the minister's and the government's response to that, be looking at ways for more effective assessments in the kinds of programs that would occur in full-day learning.

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The Chair (Mr. Kevin Daniel Flynn): Christine?

Mrs. Christine Elliott: Thank you very much for your presentation today. You did speak briefly about the categories of exceptionalities and why mental health needs haven't been identified as a separate exceptionality, and I was wondering if that might have an effect on the ability to collect data and information. Could you just elaborate on that a little bit further, please?

Mr. Barry Finlay: Yes, I can. It is an area where we receive significant requests from a number of groups, not only children's mental health groups, but other groups, primarily with a medical focus. Our challenge is, very specifically, do we wish to medicalize learning exceptionalities? If we begin to move in that direction, then it is almost infinitely related to the number of diseases and disorders that are available. Simply because they're not identified doesn't prevent a student who has a children's mental health need from getting additional special education supports. So they can still have an individual education plan that identifies their learning needs, but they haven't gone through that official process. The issue for us, really, is around the medicalization and, I would say, the further deficit focus on our children and their learning, as opposed to focusing upon their strengths. You can see that other provinces have moved in that direction, and we continue to look at this all the time.

Mrs. Christine Elliott: Just one other brief question, if I might?

The Chair (Mr. Kevin Daniel Flynn): Sure.

Mrs. Christine Elliott: It was just a question about whether you could name two or three things that you think could be done to improve our system of delivering children's mental health services vis-à-vis educational issues. Can you give us some idea of what they would be?

Mr. Grant Clarke: It's clear that school board and agency collaboration is really key to this. There are supports and services; often, they're fragmented. Really, because we're attempting to map the degree to which these relationships exist across the province, it means that we don't actually have a good database of how those supports or—if you will, a map of how those agency and school board partnerships occur. What we're hearing from the school boards is that they sometimes don't

know who to turn to in their communities, and sometimes there are issues which seem beyond the capacity of school boards to deal with and there isn't an appropriate agency referral that can be made. So, at the very least, I think step one is to maximize those relationships where we can, through the support of finding out the extent of them and where they are; secondly, identifying some better practices that are in place in a number of communities in the province and looking at them from the standpoint of: What can we learn about these models that might help other communities fashion their own better relationships to ensure that services both within the school and from whatever community supports are available are made available to students in a timely way?

Mr. Barry Finlay: If I may add a third, that is two things—focus on transitions for these children. Frequently, these children move in and out of programs, in care and out of care, and we really need to focus—and we're attempting to do that now—on ensuring that these transitions for these children are as seamless as possible. The second thing is that our children with special needs really need a team around them. It's part of the collaboration. They need to have a group of people—an interdisciplinary team—who understand them and can provide all of the different supports that are required to enable them to be successful.

The Chair (Mr. Kevin Daniel Flynn): Liz?

Mrs. Liz Sandals: This may be as much a comment as a question, but feel free to comment. One of the things that I think is a little bit confusing is that when we talk about special education, we're really focusing on issues that a child may have which interfere with their education. So if you have a child with a mental health issue who exhibits some sort of behaviour that interferes with their learning, then they might be categorized as having a behavioural exceptionality, even though that's really some sort of a mental health issue, and get support. But if, on the other hand, you had a young woman, for example, with bulimia, that may not interfere with learning because she may be a very high-achieving student. That young woman, who also has a mental health issue, wouldn't be identified because it isn't interfering with education. We have this confusion between special education, which has one focus, and children's mental health, which has a different focus. They often intersect, but it's actually two different clusters. Is that fair?

Mr. Barry Finlay: Fair.

The Chair (Mr. Kevin Daniel Flynn): We've got time for one brief question, if anybody has one. You both put your hands up.

M^{me} France Gélinas: Is it okay if I go with my brief one?

The Chair (Mr. Kevin Daniel Flynn): Yes.

M^{me} France Gélinas: I have no idea if you know the answer to this. We all know that mental illness carries an awful stigma. I was wondering: When you deal with young learners, young people, do you find that also, or at what age does it start?

Mr. Barry Finlay: I'm aware, because I come from the system, that it starts as early as six years of age.

There are children who are in children's mental health treatment centres at the age of six who have been removed from their homes and are still in in-school programs. It's one area where we're really focusing our attention about this seamless transition for these children so that they feel a part of the school at all times and are not removed from the school at all times in order to get their treatment supports. It does start very early.

M^{me} France Gélinas: So children as young as six would be stigmatized by their peers because they have a mental illness?

Mr. Barry Finlay: Children are quite resilient; even their peers are quite resilient, but mental illness, still, and mental health issues are stigmatizing at all levels, including for young children.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Mr. Finlay. Thank you, Mr. Clarke, for being here today.

DURHAM MENTAL HEALTH SERVICES

The Chair (Mr. Kevin Daniel Flynn): Our next presenter is David Clarke from Durham Mental Health Services.

David, if you'd come forward. Make yourself comfortable. There's some water there if you need it. Like all other delegations, you have 30 minutes, and you can use that any way you like. If you would leave some time at the end for questions, as the previous folks did, that would be appreciated.

Mr. David Clarke: Great. I have a prepared speech, and then afterwards, I'd be happy to answer questions.

Good afternoon. My name is David Clarke and I'm coordinator of communication and training with Durham Mental Health Services, which is a community mental health agency that serves the Durham and Central East regions. I'm speaking today on behalf of Rob Adams, our executive director.

I appreciate this opportunity to speak to the Select Committee on Mental Health and Addictions about what has made Durham Mental Health Services successful and about some of the challenges involved in meeting the complex and diverse mental health needs of our communities. I thank you for your invitation to speak and for your attention to the needs of one of Ontario's most vulnerable and underserved populations: individuals with mental health and/or addiction problems.

Just as I begin, I would also like to recognize Christine Elliott, MPP for Whitby—Oshawa, for her dedicated service on behalf of mental health issues generally and of Durham Mental Health Services in particular. Ms. Elliott's strong advocacy for the establishment of this all-party Select Committee on Mental Health and Addictions is just one recent example of her tireless efforts on behalf of individuals in need.

You may know that in 2005 Ms. Elliott received the Peter Perry Award, an award for Whitby's outstanding citizen of the year, in recognition of her exceptional contributions to the community. She has long been a supporter of Durham Mental Health Services, joining our

board in August 1989. She was board president from September 1993 to September 1997. In 2002, we recognized her service to the agency by naming one of our new residential locations Elliott House. We are so grateful for her call to action on behalf of individuals with mental health and/or addiction problems, and we've been delighted and gratified by the unanimous support that that call has received.

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There is a lot of research out there about what makes mental health and addictions services successful. Ontario governments have disseminated this knowledge in reports, including, *Making it Happen: Implementation Plan for Mental Health Reform*, from 1999; and *The Time is Now: Themes and Recommendations for Mental Health Reform in Ontario*, from 2002. For this knowledge to be effective, it has to take hold within local communities—and I mean the community, broadly speaking, and also political communities, communities within health care and human service organizations, communities of care providers. Local communities must recognize need, respond collaboratively, and be guided by best practices in doing so.

Durham Mental Health Services was created out of just such a grassroots response to need. For 22 years, we have been an example of what can happen when knowledge about mental health problems and service practices encounters a compassionate community prepared to take action.

Back in 1987, action was needed in Whitby on behalf of individuals who had been discharged from what was then Whitby Psychiatric Hospital; individuals who lacked adequate community support. At that time, boarding homes were one of the few affordable housing options in Whitby. People who lived there would be offered accommodations and meals. The conditions in some of these boarding homes were deplorable; at times, they were ghastly. Parishioners at Whitby All Saints' Anglican Church recognized that there was a need for decent, supportive housing and established Whitby All Saints' Residence Corp.

Our founders had modest ambitions. David Sims, a Whitby lawyer and an All Saints' parishioner who served as the agency's first board president, reports, "We simply wanted to provide clean, decent accommodation with good nutrition for a few people with mental health problems forced to live in substandard conditions.... To tell the truth, we didn't even know what supportive housing was or what was involved in providing it." In fact, he says if they had known at that time the kind of challenges they would encounter, they might not even have started with the project. Ultimately, guided by their recognition of the community's need and striving to adhere to the highest values, the foundation of Durham Mental Health Services was put in place.

Our first major expansions—we added case management services and also a crisis support team—followed this same organic process. Of course, we knew that these services were an integral part of the continuum of care.

More than that, we knew people—graduates of our housing program—who were living independently and who needed a helping hand. We also knew that our services at that time did not come close to meeting the community's needs. Therefore, we sought and obtained funding for Helping Partners, our case management program, and for a four-bed crisis location with a 24-hour telephone support line.

Mr. Sims has described how values impacted the delivery of services in these early days. He says that while Whitby All Saints' Church, which established this non-profit corporation, imposed no rules or restrictions, it did have two expectations. Those expectations were, first, that what the organization did would be excellent, and the second was that it would be done caringly. Those expectations—caring response and a standard of excellence—have guided the agency from its inception, with one program, one location, eight service recipients, nine or 10 total staff; to its current position, with six housing locations supporting about 40 individuals, 400 clients living in the community who receive support from 20 case managers, a crisis program that has thousands of contacts with the Durham community each year, and deep connections within the Durham community and with the whole gamut of regional services and supports.

I was fortunate enough in 1989 to be hired as a summer student at Durham Mental Health Services, which was then two years old, and I've been able to participate and to watch as the agency has grown into what it is now, and it has been an exciting story.

Time and again, our grassroots origins and guiding philosophy have enabled us to learn from best practices while adapting these practices to local conditions, resources and needs. But sometimes the process has been reversed: first of all, identifying local needs and then saying, "How are we going to meet these local needs so that we actually come across best practices?" Just as we established supportive housing before we knew exactly what supportive housing entailed, so too we were promoting recovery before recovery had a name.

An example of this is when, in the early 1990s, we expanded our supportive housing program. At that time, we established three levels of support so that as clients learned skills, connected to supports, and established routines, they had the opportunity to move to greater levels of independence. Our ultimate role in any of our programs is to work ourselves out of a role.

Recently, this model of congregate and transitional housing support has been supplemented by the development of other housing models for individuals with serious mental illness. For example, one emergent model is called "supported housing" or "independent living with intermittent or on-call staff support." At DMHS, we believe strongly that congregate, transitional housing is an integral component of the whole broad range of community mental health supports. No one model of housing support can meet the broad and divergent needs of all individuals with mental health problems.

For example, independent living with intermittent or on-call staff support does not meet the needs of many

individuals who are transitioning from a structured, 24-hour hospital setting or from a home where family members have been heavily involved in providing care.

When we consider the continuum of services that are available in an ideal mental health system, there has to be a range of options available to meet the needs of individuals at any stage of recovery. Congregate, transitional housing is not a solution for every person, but it is a needed support for many. We have seen this in the experience of those who have benefited from this service, and we have also heard it in the grateful testimony of family members who are seeing their loved ones thrive in independent living, in many cases for the first time in their lives.

One of the pressing issues in mental health service delivery today is the need for collaboration across services and sectors to meet complex needs. This is so whether we're considering the needs of individuals who have concurrent mental health and addiction issues, the needs of families in crisis or the needs of individuals with mental health issues who languish without adequate treatment in provincial jails.

The complexity of presenting problems that community mental agencies are encountering seems to be increasing. Problems are growing more complex. Individuals who are seeking support do not care at all about which service provides support. The only question that matters is, do they receive support that is compassionate, efficient and effective? This matters particularly when it comes to mental health services, given the pervasive stigma associated with reaching out for help, the paucity of information generally known about mental illness and the frustration of navigating a system that, as is well known, at times can seem more like a maze.

I would like to briefly highlight two of Durham Mental Health Services' cross-sector partnerships which are helping to create solutions to complex problems. The first is our partnership with Durham region's child and youth service providers to offer integrated crisis response. The complex needs of families in crisis are best served through such partnerships.

Traditionally, child/youth and adult services have operated in isolation. Families have not experienced the system as seamless and integrated. By integrating a crisis service response, each sector can contribute its resources and its expertise, and families are receiving a holistic and humane response.

When child/youth and adult services integrate in this way, it also helps to facilitate a seamless transition for a young person who has mental health problems from child and youth supports to the adult mental health system, which will be providing service to the individual as soon as they hit 16 or 18.

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Another example of these cross-sector collaborations which are so vital is Durham region's drug and mental health treatment court and the associated youth community restoration court. When I think about these courts, I think of how judges and prosecutors want to be catching

bad guys, criminals, not people who are ill. These courts constitute a cross-sector collaborative approach to the problem of addiction. Durham Mental Health Services partners with addiction services and with justice system resources to provide a humane, rehabilitative alternative to the punitive approach to addictions. Durham's drug and mental health treatment court promotes recovery, reduces pressure on the justice system and reduces recidivism. Individual outcomes and public safety are both enhanced through this collaborative and evidence-based approach. In both of these examples of service integration and in many others, differences in philosophies, policies and service delivery models need to be creatively addressed. But the effort is worth it when it results in closer partnership and enhanced capacity to respond to complex community needs.

What Durham Mental Health Services contributes to these partnerships is our expertise on community mental health. From the beginning, we have closely adhered to our mandate and to our guiding vision. As we've recognized needs, we've responded to those needs creatively. For example, as our housing program grew, we recognized the need for more local day programming options, and so we applied for Trillium funding and started our own day program and our own pre-vocational program. Working with families, we recognized the critical role that they play in recovery, and also their desire for information, linkage to resources, and connection to others who share similar life experiences. So we started our family support program. At the same time, we recognize that we have a core group of functions on which to focus, thereby avoiding the temptation to do so many different things that we cannot achieve excellence in any.

Finally, before offering some practical suggestions that are based on our experience—our experience, I think, is one that is representative of community mental health agencies, at least ones in the GTA—I would like to draw attention to a potential shadow side of what has been an increasing emphasis on quantitative outcomes. We recognize, absolutely, that service providers need to demonstrate objectively that their services are providing value. At the same time, an exclusive or disproportionate emphasis on quantitative outcomes can compromise quality. When service volumes and outcome measures are the primary focus, there is a temptation among service providers to offer quick, in-and-out service and maximize the number of people receiving services. We become service brokers rather than relationship builders. Relationship building is right at the heart of recovery and of community mental health work. We feel strongly that it must also be central to the vision of a transformed mental health system.

On the basis of our experience at Durham Mental Health Services, I offer the following suggestions on how governments might help address the burden of mental health and addiction problems.

First and foremost, the foundation of everything is to raise awareness of mental health problems and help to eradicate stigma. As long as people are feeling that

mental health problems are something that is never going to affect them—something strange and aberrant—the motivation to collaborate as a community and to address mental health needs won't be there. So governments can support communities throughout Ontario, in homes, schools, workplaces, faith associations and health care sites, to recognize, first of all, the commonality of mental health problems, and secondly, their burden, but also our capacity, individually and collectively, to alleviate that burden.

Secondly, governments can help to facilitate communication and co-operation between diverse sectors, from the health care system to the justice system to the child and youth system, and, particularly, work to reduce the barriers between mental health and addiction services, which have long worked in isolation despite the body of evidence showing that an integrated response to mental health and addictions is the only effective response.

Thirdly, provide adequate resources to individuals and communities, not only in terms of providing funding for evidence-based services but also in terms of providing affordable housing, sustainable income rates for individuals with disabilities and supported employment programs that can help individuals with chronic mental health problems get off disability.

Fourthly, promote knowledge exchange, set service standards and ensure accountability to those standards so that what is known to be effective is actually being implemented by mental health services, large and small, across Ontario.

Finally, focus on enhancing and mobilizing a local capacity so that communities can respond to the burden of mental health problems in ways that respect local conditions and leverage local resources.

I thank you for this opportunity to speak to you today. I speak for everyone at Durham Mental Health Services when I say that we've been energized by the growing media attention to mental health and addiction issues, by the work of the Mental Health Commission of Canada and by the establishment of this provincial committee. We look forward to working in partnership as we all, together, address the aching burden of mental health problems in Durham region and across Ontario.

The Chair (Mr. Kevin Daniel Flynn): Thank you, David. Thank you for that presentation. We've got time for about three questions. Let's start with Christine.

Mrs. Christine Elliott: Thank you very much, David, for your presentation. Certainly I'm very proud of the work that Durham Mental Health Services has done, and you really do tremendous work in our community. I think some of the issues that you've raised certainly move across Ontario. I think the range of supportive housing that you provide is really important in terms of the work that you do. I wonder if you could just elaborate a little bit more on the differentiation in the types of housing options that you have allowed for.

Mr. David Clarke: Certainly. We've got a supportive housing program that provides transitional housing.

There are three types of housing: First of all, people who are first leaving a psychiatric hospital or who are moving out from a family home for the first time go first to a house called McKay House, which is double-staffed 24 hours a day. It's where people are first connected to community resources. They work one on one with a dedicated individual, who will help them to set goals and to progress toward those goals.

When individuals are doing well at that level of support, the next level of support is offered at a house called Sims House, and that is still staffed 24 hours, but it often is single-staffed, and there are times when staff will go out of the building. There's more of an expectation that individuals living there will be taking ownership of their routines and of the upkeep of the house and of staying in touch with their health support networks, with their day programs, that kind of thing.

Finally, when individuals are doing well at that level, there are four houses that we offer that offer a range from 20 hours of support a week to 40 hours of support a week. So it's really, in a way, independent living at that time, but there is this safety net there so that if individuals are moving out to this low-support housing, they still are supported by Durham Mental Health Services; they still have on-call access and scheduled contact with staff support.

From there, individuals can move to the community, but still be connected to our case management program. They always are supported throughout every stage. As well, we've got our 24-hour crisis support so that individuals not only in the community, but also DMHS service recipients, can access that program if they do have mental health needs and they need some support attending to those needs.

The Chair (Mr. Kevin Daniel Flynn): Thank you, David, for that answer. France and then Helena.

M^{me} France Gélinas: I, too, was really impressed, and I thank you, Mr. Clarke, for coming. It's nice to see that sometimes, it does work. I'm really proud that in Durham, you got it together. The more I learn about mental health and recovery, the more I see that in order for recovery to be successful, you need housing, you need support and you need an income. It seems like you were able to put all of that together.

Of course, as I listen to you, I'm thinking, "Jeez, I would like to have that in my community." So the next question is, where do you get your funding for your double-staffed 24/7 supportive housing?

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Mr. David Clarke: Primarily, the funding for our services now is routed through the Central East local Health Integration Network and stems from the Ministry of Health and Long-Term Care. We also receive funding through some Trillium proposals. There is funding through the region of Durham for domiciliary shelters—that's some of our low-support housing. We also get some funding for our human service and justice coordinated programs, like our court support services or our release-from-custody workers; some of that does come

from the Ministry of the Attorney General. So it's a combination of governmental resources.

M^{me} France Gélinas: Wow; very impressive. As I say, I'm starting to understand, they need housing, they need support and they need income. Where do the people you treat and work with—what are their sources of income?

Mr. David Clarke: Primarily, when people are beginning with our programs, they're receiving ODSP for the most part. Sometimes, in fact, getting a person connected to the Ontario disability support program income support is a goal that we set from the start with clients. But ODSP has the flexibility that people can earn \$170 a month, first of all, free and clear without having any of that clawed back, which is an incentive for people to explore vocational opportunities. Then, as people are getting more comfortable with vocational opportunities, they can continue to have an outside income; it's just that as they earn more and more, a more significant portion of their ODSP is taken back. But, an individual, even if they're earning a decent income on their own, can still be supported by ODSP for—and I can't remember the length of time right now, but in order to, for example, still receive health coverage, dental coverage and those needed coverages. So often the employment that they're going into will not have that kind of benefit plan.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Mr. Clarke, for that answer. Next is Helena.

Ms. Helena Jaczek: Thank you, Mr. Clarke, and congratulations to Christine for having had such an important role in this organization, because it sounds really exemplary.

Since some of my questions have been answered already, I would like to just concentrate on the case manager role. You mentioned 20 case managers for a client load of 400. So the ratio is essentially one to 20, on average. Knowing that everybody always wants more staff, is that reasonable? Is that manageable in terms of a ratio?

Mr. David Clarke: Yes. That standard is the standard that's set out in the Ministry of Health documents around intensive case management. It's very individual because you could have a client who has very high and complex needs and is in crisis at that time and is taking up a good deal of time, but then you may also have clients who have set goals and achieved goals and who are transitioning off of case management to be independent, but know that we're there as a support as needed and there's always an open door to return. So it does tend to balance out. The only way at all that it can work is if our case manager is working in close co-operation with the variety of health, human services and naturally occurring resources—libraries, gyms and faith associations—that are there in our community.

Ms. Helena Jaczek: Do you try and keep the same case manager for that client throughout the process?

Mr. David Clarke: Yes, unless problems develop in terms of a person seeing an individual as the only person that can support them. Those kinds of dependency rela-

tionships can develop and they can interfere with recovery, but generally speaking, it's best to establish one trusting relationship, and that also helps case managers, because so often it might not be that they're seeing results immediately with every client that they provide service to, but when they stay connected to the clientele over a period of time, they can be gratified as they see progress, and it revitalizes them as well.

Ms. Helena Jaczek: Just one final question: What sort of qualifications do your case managers have?

Mr. David Clarke: Most of our staff are coming out of college programs. Specifically, human services counselling programs are, I would say, probably the most frequent educational credential for the staff of Durham Mental Health Services. One thing that we've been gratified by is that colleges are recognizing the need for people to have not only experience with and knowledge of mental health problems but also addiction problems. For example, the local college offers a postgraduate program that combines knowledge of addiction and mental health. I feel strongly that it's people who are coming from those integrated programs who are really going to be the leaders as they enter the field. That is the future, for sure.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Mr. Clarke, for coming today. Thanks to the committee for their questions.

MINISTRY OF CHILDREN AND YOUTH SERVICES

The Chair (Mr. Kevin Daniel Flynn): Our next speakers today are from the Ministry of Children and Youth Services, if they would come forward. We've got Judith Wright, Aryeh Gitterman, Gilbert Tayles and Marian Mlakar.

Thank you very much for coming today. As with the other delegations, you have 30 minutes. You can use that any way you like, but we would appreciate it if you would leave some time at the end for some questions from the committee. The floor is all yours.

Ms. Judith Wright: I understand the purpose is discussion. I believe we've handed out a slide package.

The Chair (Mr. Kevin Daniel Flynn): Perhaps you can introduce yourself, as you speak, for Hansard.

Ms. Judith Wright: Okay. I'm Judith Wright, deputy minister at children and youth services. It is a pleasure to be here to talk about services for children and youth who are experiencing mental health issues. Let me introduce the people I have with me. To my right is Gilbert Tayles. Gilbert is the assistant deputy minister for the youth justice division, which looks after children who are in conflict with the law. To my right is Aryeh Gitterman, assistant deputy minister at the program and policy development division, which is responsible for the policy framework for children and youth services. Beside me is Marian Mlakar, who is the director of the children and youth at risk branch, which is also responsible for policy related to children's mental health.

I think we distributed a slide presentation. I'm going to walk you through it at a very high level to leave a chance for discussion and to help frame that discussion.

Let me begin, first of all, just on page 2. In 2006, the ministry released a policy framework on children's mental health which was called A Shared Responsibility, and I believe we've provided you with a copy of that. The purpose of this was to set a framework for children and youth mental health services, and part of what it did was actually provide a definition of what children and youth mental health is and to give that definition on a continuum from prevention and promotion right through to the more serious mental illnesses with clinical conditions that children and youth experience. On page 3, we've outlined what the continuum looks like.

On page 4 is a reminder that in addition to the services that are provided by children and youth services, we also are linked with addiction services, which are funded by MOHLTC, and eating disorders, also funded by MOHLTC. The Ministry of Children and Youth Services also provides funding for complex special needs. These are children and youth who have one or more disabilities, in most cases, an incredibly complex set of needs, some of which are mental health and some of which are physical disabilities. We also provide funding for that.

Page 5 has some prevalence data which I think will probably be familiar to you by now at this point in your hearings. Just to go over them: Between 15% and 21% of children have at least one mental health issue; 25% of youth aged 15 to 24 have reported a mental health issue; 14% of children and youth suffer from a diagnosed psychiatric disorder; 5% of children and youth have experienced depression before the age of 19; and suicide is the second-leading cause of death for youth 15 to 19.

Page 6 talks a little bit about the responsibilities of the ministry itself. We are the lead ministry for children and youth who are experiencing mental health issues. It is important to note that within our ministry, mental health services are not a mandated or entitlement program, so the services are provided to the extent that the resources are available to support them. We are responsible for children up to the age of 18. The services are primarily delivered through a range of community services.

Children and youth mental health services, as a number of us have discussed before at public accounts, have grown up from the community, so there's a full range of services that can go from a \$200,000 agency to a \$55-million agency. There's a broad range of service agencies that we support. The services that they can provide include counselling, identification of issues, individual and group therapy, parental education, supports for families and crisis intervention, so it is a full range of services that are provided by the community organizations.

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In addition to the community organizations, we also provide mental health services for youth who are in conflict with the law or at risk of being in conflict with the law. The ministry directly runs two facilities, Thistle-

town Regional Centre and the Child and Parent Resource Institute, which provide very specialized services for special needs children and youth, including mental health issues. We support a telepsychiatry program, specialized programs for aboriginal children and support for outpatient services in 17 hospitals, and finally, we provide funding to the Centre of Excellence for Child and Youth Mental Health. The purpose of that funding is to reinforce the importance of evidence-based research and to have evidence-based research disseminated to the agencies that are providing the service.

On page 8, we just touch a little bit more on telepsychiatry and aboriginal programs.

Page 9: I'd like to talk a little bit about the assessment tools that are used. I think, as you probably know, one of the challenges around children and youth mental health services is the standardization of both intake and assessment. As part of the framework and in recognition of that, the ministry does support three common assessment tools. One is the brief child and family phone interview, which is an assessment of the child's needs on intake and which is supported through funding that we give to CMHO. The second is the child and adolescent functional assessment scale, or CAFAS, which is a clinical assessment for determining the functional impairment of children and youth and which is supported through the Hospital for Sick Children. The third is the risk-needs assessment, or the RNA, which is used to assess youth in conflict with the law and their risk of re-offending. I think as we've mentioned at public accounts, we are currently reviewing the first two of these, BCFPI and CAFAS, both to just confirm that they're still current with the latest evidence and also to take a look at their doability and usability.

As you're aware, children and youth mental health services—when you look at the full spectrum, we aren't the only ministry that's involved in them. On page 10, we talk about the role that MOHLTC plays, the role that education plays—I believe you spoke with them this afternoon—and health promotion.

One of the reasons that we actually did the framework was to reinforce the importance of all of the players involved in mental health working together to have a common, coordinated and collaborative approach to children's mental health. We have a bit of distance to go on that, but the framework provides a basis from that discussion. On page 11, we just set out some of the objectives of the framework.

I'd like to talk a little bit now about the mapping activities that the ministry has undertaken. As a first step in the implementation of the shared responsibility framework, the ministry made a decision to work with the sector to identify all of the services that are currently being given under the children and youth mental health label in the communities and to look at those services that are currently being provided against the framework to identify what's on the ground, what are the gaps and can we develop a consensus on what we shouldn't be investing in, in terms of children and youth mental?

This has been a very significant exercise. Over 370 agencies participated. We have 1,500 survey instruments that were developed. We are working with MOHLTC and education in order to incorporate some of their data into this mapping exercise, and we've also looked at other research.

We are currently taking that data and developing it into what I'd call regional maps that we will then go out and talk to the community and the community agencies about. "What does the data tell us about what services are in your community and what they do, and what do we want to do with this data now that we have it?" We do have some very preliminary data results on page 13 from the mapping. We know that an estimated 255,000 children and youth were served through these agencies in 2007-08, and that youth between the ages of 14 and 16 were the largest users of the service.

We also identified the services that were being provided against the four levels that are in the framework. So you can see from page 13 that 21% were at level one, which is a child or a youth not at risk or not experiencing mental health problems. Twenty-eight per cent of the services were for children at risk of experiencing some mental problems or illnesses. Levels three and four are the more serious levels: 33% and 18%. We also know from this data that there was an average wait for services of 38 days from the time that the assessment was made. Approximately 75% of children experienced improved functioning as a result of the intervention.

We outline a little bit on page 14 some additional work we're doing on mental health and some of the additional findings. I did want to close with just talking a little bit about the findings that are more at a policy level that we have on page 16, as I think they're probably the ones of most interest to the select committee. I think what we're seeing already in this data, none of which I think will be a surprise to you, is that first and foremost there really is a need to have better coordination between the services being provided through children and youth mental health education and health, and that part of that is actually a greater sharing of information about not only what the services are but what the client is receiving. Part of that is actually the need to look at a more standardized assessment process, possibly even a single common assessment process, and that information about the assessment process should also be shared better between the agencies.

We're also finding, I think, as we indicate here, a need to talk more and develop better alignment around addition services, particularly for youth at conflict with the law or at risk of being in conflict with the law.

Two additional findings: One is the need to ensure that there's a better, stronger, perhaps, voice for parents and clients in the way the services are designed and delivered; and finally, and this is the point the auditor has made to us in the past, the need to have stronger data on wait times.

That's a very brief run-through of the slide package. I hope it wasn't too brief.

The Chair (Mr. Kevin Daniel Flynn): No, that was just right, and you've left quite some time for questions. This time we're going to start with France and then Helena.

M^{me} France Gélinas: My first question is not that important, but we'll put it aside quickly. You've said that you had 373 agencies that participated. You fund 440. What happened to the other 67?

Ms. Judith Wright: When we started out—actually I'll let Aryeh talk about this in more detail since he led the mapping exercise—we started with some rigorous definitions about what mental health is and what agencies were in and out of that according to that definition, so that narrowed it down from the number that are funded. In addition, some of the agencies funded under that number are complex special needs agencies that don't necessarily meet the mental health definition. That line funds both complex special needs and mental health. I don't know if you want to add to that.

M^{me} France Gélinas: So the 373 are all of the transfer payment agencies that provide mental health to children.

Ms. Judith Wright: And met the definition that we were looking at in mapping.

Mr. Aryeh Gitterman: I would just add, not a qualification, but just for clarification, the mapping was a point in time, so periodically there are time-limited, one-time funds available for certain things, so that can have the number fluctuate a little bit over time.

M^{me} France Gélinas: Okay. Something we've talked about here is that there are some great things happening in Ontario. There are also some areas, as you said, because those programs grew from the ground up, that are not getting as many resources through the mapping or any other thing that your ministry's doing. Are you looking at equity of access?

Ms. Judith Wright: Can you just clarify what you mean by equity of access? That's a vague term.

M^{me} France Gélinas: We just had a gentleman from Durham explain to us everything that is available there. Mind you, it was for adults. Do we know, or is there a way of knowing, if a service is available in Sudbury, if the service is also available in North Bay?

Ms. Judith Wright: What the mapping data will tell us is what services are available where, and it will tell us, I think within a certain degree of rigour, whether that service is comparable. As you know, because we're not a mandated funding—that's a bit why I was going with the equity of access—the services are those which have developed according to the community need and that we have been funding. I think the mapping exercise for the very first time will enable us to talk to communities about, "Is this the kind of service that you think you still need?" and is it representative of what we think the appropriate use of our resources should be.

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M^{me} France Gélinas: I understand the mapping gives you a point in time as to services, who are the beneficiaries, how much they cost etc. The part that is assessment

of the community needs will be done through community forums, using the mapping as—

Ms. Judith Wright: Right.

M^{me} France Gélinas: Okay.

Mr. Aryeh Gitterman: And, I would just say, adding information also collected through our exercise with the Ministries of Health and Education, because that gives a more complete picture of what the current provision is in a community, which connects to the point the deputy made earlier about the alignment between the different methods of delivering children and youth mental health services. One could be offset a bit by the other, so the complete picture is required first.

M^{me} France Gélinas: I realize that you are preliminary, and I'm really happy to see some of the findings from the mapping have already come out. Are there already directions to follow as to best practices that are developing or ideas for making the children's mental health system better for everybody?

Mr. Aryeh Gitterman: Do we have some ideas already? Yes, of course we have some ideas.

M^{me} France Gélinas: Could you share them with us?

Mr. Aryeh Gitterman: That's a different question. I think the page on findings is a hint as to the ideas we're developing further, if I can say it that way. We haven't tested all of these ideas out through the appropriate channels.

One of the forms we will be using to test out these ideas are the workshops we'll be conducting back with the agencies who provided the information. We're going to feed back the information and layer that information with our findings and assumptions about the things that have to be done now. So that last page gives a hint.

For example, we do think the question of access that you raised is a very important question. Are the right children finding their way into the right services, programs and agencies? I'll just use this by way of example: Because children are in schools a lot of the time, do schools and personnel in schools have the right tools at the right level to help make some of the right recommendations about that route to the right programs and services? We've started those discussions with our colleagues in education, but again, that's an idea we have at this point; it's not a direction. We have to test that out to see if it conforms with the notions that the people in the field, in the agencies and in the schools have. But it's an example of one of the directions.

The Chair (Mr. Kevin Daniel Flynn): Thank you. It's time to move on. First from this side is Helena, and then Bas.

Ms. Helena Jaczek: Well, thank you for your presentation and going into some detail around the mapping. I've certainly heard from the agencies in my riding and, in York region as a whole, from the providers. I must say, they are distraught in terms of the waiting lists that they're trying to manage in York region, given the growth in York region. They come to me in my constituency office, they come at every opportunity to express their absolute dismay around the funding provided to the

agencies within York region. They see the mapping exercise, they understand the reasoning and so on, but they want to be assured of some sort of progress.

We've heard in this committee about early recognition and early access to a treatment plan, and when you have such a very large number of children on waiting lists, those in that community, the providers, obviously, are very anxious to somehow provide sooner. What is your time frame for the mapping exercise and for solutions and, hopefully, for some sort of equity in terms of service across the province?

Ms. Judith Wright: I can appreciate, actually, that the providers are a little anxious. I think that we underestimated the amount of information we would need to manage when we got the 1,500 survey results—plus it's been a combination of managing data and doing a qualitative analysis of what the agencies told us. So we've taken longer than we had wanted to to get back to them. As I said, we're forming them into the community maps and the provincial maps. I think we're targeting to take those out in the fall—

Mr. Aryeh Gitterman: We're starting our first discussions, just to make sure we have information that makes sense back to the agencies, in June or July, just to make sure we have the right presentation—and then rolling out from them through all of our nine regions, and many of those regions will have more than one workshop. So they'll start immediately after that.

Ms. Judith Wright: And just to recognize that we understand that wait lists and wait times are a very difficult situation for parents, children and youth, and the providers. In light of this not being a mandated service, we are optimistic that the data in the mapping will enable us to have a better understanding of whether the child or youth is on the right waiting list for the right service. It still won't end waiting lists, for sure, but at least will help bring a little bit more understanding to that situation. York has many special challenges by virtue of, as you just said, the extraordinary growth that's happening in that area.

The Chair (Mr. Kevin Daniel Flynn): Bas.

Mr. Bas Balkissoon: Thank you for your input. It's nice to know you're doing some work—you say you're not mandated to look after mental health but you're doing some work there. The previous group said they received funding from the Ministry of Health, through the LHINs. They received funding from the AG's office, and they're handling ODSP clients, which is the Ministry of Community and Social Services. I suppose the Ministry of Health Promotion is going to get into the ball game in the future, because when they were here they were really at the preliminary stage of doing anything seriously. Which ministry is mandated to take total control of mental health?

Ms. Judith Wright: Just to be clear in what I mean by "mandated," the Ministry of Children and Youth Services has the mandate and is responsible for funding agencies that provide services for children and youth mental health that are community-based. The Ministry of Health has

responsibility for the medical-based services, and education has responsibility for services in schools—although we work with both of those service providers.

Mr. Bas Balkissoon: But who is in total control, who can say, “We’re doing a good job and we’re succeeding?”

Ms. Judith Wright: From a policy perspective, it is the Ministry of Children and Youth Services that says, “Here’s the policy framework.” When I was saying we don’t have it mandated, I mean our programs are not entitlement programs, but we do have a mandate to take responsibility for it. I think I said in my remarks that we recognize that there is a real need for better coordination, both at the community level and at our level, of what services are being delivered by the three big service delivery areas: health, the Ministry of Children and Youth Services, and education.

Mr. Bas Balkissoon: But if you recognize that there needs to be better coordination, where would you put that coordination—in which ministry’s hand?—and give somebody responsibility; that they’re accountable, and that services are accessible, and we’re meeting the needs of the public and it’s measurable? Where do you see that resting?

Ms. Judith Wright: Good question. I think from the perspective of the community-based services—so not necessarily those that are covered by the LHINs and health—the best place to put that responsibility would be with the Ministry of Children and Youth Services. Having said that, the best place would be to put it in some kind of community capacity, because really what you need in children’s mental health is that community governance model that enables those services to work together in a way that’s responsive to the community they have.

Mr. Bas Balkissoon: If I go back to the work we did on the poverty committee, at the end of the day we recognized that we were not serving the client, truly, because we had all of these people doing different things, and the client was not the centre of that whole service model, and we needed to change. We’re moving toward making that change. I’m sitting here asking, in mental health, who is the prime person who requires the help so that they live a fuller life? Again, it’s the client. If we fund agency A and agency B, but we’re not sure the client is getting all the services they need, we’re not improving the system, are we?

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Ms. Judith Wright: No. Agreed.

Mr. Bas Balkissoon: So I want to know who’s best to coordinate that—

The Chair (Mr. Kevin Daniel Flynn): It’s time to move on, on that note. Thank you, Bas. And thank you for your answer.

Who’s up next? Sylvia?

Ms. Sylvia Jones: Thank you, Ms. Wright. I also want to talk about the mapping that ties into what Helena was referencing. On page 13, the average wait for service is 38 days. I’ve got to tell you, that jumps out at me,

because in my experience in my community, when a staff member highlights the need for an assessment within the school system, the assessment can be a year and a half to two years. So my question for you is, that average wait of 38 days for services: Is that after assessment? So assessment to service?

Mr. Aryeh Gitterman: Just to be clear, the information on wait times on this page refers to community-based agencies, not wait times in the school system.

Ms. Sylvia Jones: Yes, I understand that. But what happens is, the school staff say, “I think you should get your child assessed.” It goes to a community-based service, and that’s where the wait time is.

Mr. Aryeh Gitterman: Yes. So the wait time referred to here is from referral to beginning of service. So I phone or I’m referred to and I have the initial intake conversation. Before service begins, it’s an average wait time of 39 days. But that’s an average. What we have realized in the mapping exercise—and this had never been done before—is that there are 1,500 different programs being delivered by our agencies. Each of those programs may have slightly—and again, this is a description; whether it’s good or bad is a whole separate discussion. Each of those programs may have a separate wait time associated with it.

When we refer later in the package to one of the steps or avenues of work that we believe has to be done, it is in fact landing on clarity on what the wait time is, clarity on how we will collect that information, and then a determination, which is a separate exercise, as to whether we find that wait time acceptable or not and whether we wish to set any different targets for lowering that wait time. But that’s an average across very many different programs.

Ms. Sylvia Jones: I understand. So can you provide the committee with where those numbers are coming from? Because again, it comes back to—if I’m hearing from parents that it’s a year and a half, then somewhere in Ontario someone’s waiting an hour.

Interjection.

Ms. Sylvia Jones: Exactly my point. So can you provide that to the committee?

Mr. Aryeh Gitterman: It’s not in a presentable package yet, but we will be able to provide information on wait times by program, by region of the province. And you are right: There is quite a lot of variability, which is what led us to the conclusion that we’ve already talked about.

Ms. Sylvia Jones: So when you say “by region,” are you doing it by LHIN? What is the breakdown by community?

Mr. Aryeh Gitterman: We’re doing our agencies by our regions.

Ms. Judith Wright: We have nine regions.

Ms. Sylvia Jones: Okay.

Mr. Aryeh Gitterman: But we’re also collecting information from the Ministry of Health through their hospital-based programs, so that’ll be a different organizational structure.

Ms. Judith Wright: We've had this discussion in other forums, but wait times—there will be duplications of kids who are on more than one wait list. So this average wait time data also has to be taken into account with the fact that—it has to be looked at within the fact that we don't have a unique way of having a wait time for each kid.

Ms. Marian Mlakar: It also takes into consideration all the levels across the continuum. Some children would be at level 4 and they'd be requiring fairly urgent service, and others would be at the more prevention level. So the community dialogue, we hope, will also talk about what we can tolerate around a wait list. Maybe we're more comfortable with having a longer wait list for a child who's not in dire need and less of a timeline for children who really urgently need mental health care.

Ms. Sylvia Jones: Right, which the CCAC currently does.

Ms. Judith Wright: A version of it, yes.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for your presentation today. It certainly is appreciated. You raised some very interesting issues and generated some good discussion. Thank you for coming.

Interjection.

The Chair (Mr. Kevin Daniel Flynn): We certainly will.

ONTARIO SENIORS' SECRETARIAT

The Chair (Mr. Kevin Daniel Flynn): Continuing right along the age continuum, we go from children and youth services right to the Ontario Seniors' Secretariat. We've got Diane McArthur, assistant deputy minister, and if you'd introduce your staff, Diane, that would be appreciated.

Ms. Diane McArthur: I certainly will.

The Chair (Mr. Kevin Daniel Flynn): Like everybody else, you've got 30 minutes. You can use that any way you see fit. If you would leave some time at the end, we'll share that as appropriately as we can.

Ms. Diane McArthur: Absolutely. I am Diane McArthur. I'm with the seniors' secretariat. This is Katherine Mortimer and Elizabeth Esteves. I'd also just like to note that we have a student with us, Ana Talag, who has done some work on the presentation and who is with us from McMaster University.

I'd like to start today by thanking the committee for the opportunity to present and for including the mental health needs of seniors within your work, and for recognizing that mental health is a broad issue beyond the scope of any single service, sector or organization.

Many of the things you'll hear me say I think you've heard already. The thing that is unique, I think, is the dynamic that happens between aging and mental health.

My presentation today will cover the seniors' secretariat mandate and highlight some relevant demographic and social trends. It will provide you with a quick overview of mental health and addictions among seniors; some key initiatives that the secretariat was involved in;

some of the barriers that exist for seniors with mental health and addictions; and finally, some opportunities on how to better meet the needs for seniors with mental health and addictions.

Seniors face some unique challenges that increase the complexity of their physical and mental health needs. Seniors with mental health and addictions face both the stigma of mental illness and ageist attitudes. Population aging means that these challenges are only going to intensify.

Good mental health is the result of many factors. There is no single way to promote it, and there's still a lot we don't know about seniors' mental health and addictions in particular. We definitely need more research and a better understanding of the current and future needs of seniors with mental health and addictions issues if we're going to help to create a basket of services that are required to respond to those needs. Ideally, this response would be provided within an integrated and coordinated system of services, ministries and organizations.

On slide 3, you'll see a quick overview of the seniors' secretariat mandate. Unlike many of the presentations that you've heard today, we do not directly deliver services. We are focused mainly on leading policy initiatives for seniors, working across ministries and jurisdictions to make sure that the views and the needs of seniors are taken into account as policies and programs are developed.

We also work with public education and awareness both for seniors and for the general public about aging, the contributions that seniors make to society and about the availability of programs and services that seniors can have access to.

We work closely with many seniors' organizations to do this, and through the seniors' secretariat liaison committee, the advisory committee on seniors' housing, and the advisory committee on long-term care, the 11 largest seniors' organizations in the province have direct access to ministry staff from a variety of ministry program areas. We also arrange for key interest organizations, like the securities commission, to come and meet with the organizations so that they have an opportunity to discuss and have input on the development of a variety of programs and initiatives that affect seniors' day-to-day lives.

We've provided you with a list of the 11 organizations in the materials. I know that a number of them would be very pleased to meet with the committee during your consultation process.

On slide 4, I'll just speak quickly to some of the demographic and social trends that I'm sure we're all well aware of.

Ontario is home to 1.7 million seniors. That's about 13% of Ontario's total population and 38% of the nation's seniors population. That is a fast-growing demographic. The numbers will more than double to 3.5 million by 2031.

The fastest component of that growth is going to happen with people over 85 years of age. Older women will continue to outstrip the number of older men—that perhaps was an odd figure of speech.

Chronic disease is increasing the complexity of their health needs. And as with the rest of Ontario's population, seniors are becoming increasingly diverse.

Currently, over 70% of informal caregiving is done by family, friends and others, and mainly, that is by women.

Changing fertility patterns, reduction in household size and increasing geographic distance between family members are going to challenge our ability to provide intergenerational care.

There is a growing expectation among seniors that we'll be able to age in place and remain in our own homes as long as possible.

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All of these trends will affect both the demand for and our capacity to meet future health and social service needs, including those for seniors with mental health and addiction issues.

In the appendices in the handout provided, we outline some of the mental health and addictions issues faced by seniors, including statistics on prevalence. While I won't cover these statistics in detail, it is important to keep in mind that seniors are a heterogeneous population. Their needs and circumstances differ according to their mental health condition, life experience, gender and country of origin.

I'll speak to these needs along two dimensions: first, the aging of people with mental health and addictions issues and then, those who develop a mental health or addiction issue as they age.

Some conditions like psychosis are more likely to develop in early adulthood and may be marked by a cyclical pattern of recovery and relapse. In the most extreme cases, these conditions can limit employment, income and housing at various points throughout their lives. They can be extremely isolating; stigma, as well as behavioural, cognitive and affective symptoms, may make it difficult to establish and maintain long-term relationships and can contribute to the loss of social networks over the life course. As a result, care and support systems can't depend on informal caregiving to take the lead role, to advocate for these seniors or to help them navigate the system.

Finally, as people with mental illness get older, additional needs and complexities are likely to arise as part of the aging process. These can include mobility restrictions, memory impairment, difficulty with self care, chronic physical illness or cognitive and behavioural difficulties due to dementia. Mental health and addiction service providers need to be prepared to anticipate and deal with these complexities.

For the general seniors population, the most commonly discussed mental health issues continue to be depression, alcohol addiction and the impact of dementias. Risk factors for developing a mental health issue or an addiction later in life include social or emotional isolation, particularly as they relate to critical transition points: the loss of a spouse, unemployment or retirement, disability, illness, loss of independence, and caring for a spouse with dementia. The literature tells us that diag-

nosis for these seniors is particularly problematic as symptoms are sometimes overlooked as being part of the "normal aging process."

It's important, therefore, that health service providers and informal caregivers be educated about how to recognize these issues, because early intervention may mitigate loss of function and independence, delaying cognitive decline and reducing the health service use and emergency room visits.

On slide 6, I'll give you a quick overview of some of the initiatives that the Seniors' Secretariat has been involved in. It's important, though, to stress that seniors' mental health requires a variety of direct and indirect responses. As I said, we're not directly involved in direct service delivery, though we have led several initiatives that do relate to the general area.

I'll begin on slide 7 with Ontario's strategy for Alzheimer disease and related dementias. In addition to mental illness, seniors suffer from a variety of behavioural and cognitive disorders associated with brain diseases such as Alzheimer's disease and related dementias, or ADRDs. ADRDs are the most frequent cause of challenging behaviours in older adults. They also affect the health and well-being of the caregivers, many of whom are seniors themselves, resulting in burnout and depression from lack of support and respite. We know that caregiving is disproportionately provided by women and that depression is two times more common among senior women than senior men. These realities certainly underscore the mental health impacts of dementia.

Ontario's strategy for Alzheimer disease and related dementias was the first of its kind in Canada. Our secretariat led the development of this strategy with advice from a broad range of stakeholders and we worked closely with the Ministry of Health on its implementation.

Beginning with a five-year investment of \$68.4 million and 10 initiatives, the strategy has resulted in \$13 million in ongoing funding for respite programs, psycho-geriatric resource consultants and public education coordinators. The strategy has also supported the development of two education programs for front-line staff.

Next, let me mention our work on elder abuse. Elder abuse takes many forms: physical, emotional, financial, and it can also be neglect. It is often perpetrated by those who are closest to the senior. Mental health and addictions problems can increase the vulnerability of seniors to abuse. It affects their ability to judge their own risk and vulnerability to exploitation by strangers or by someone they trust. Mental health and addictions can also be experienced by the people who are closest to seniors, increasing the risk of abuse.

Ontario's strategy to combat elder abuse has been implemented through a partnership with the Ontario Network for the Prevention of Elder Abuse. Through the strategy, regional consultants work with 52 local networks and service providers to improve local service coordination, help train front-line staff who serve seniors, and increase public education about elder abuse and

where seniors can go for help if they're experiencing abuse. These networks include members from the mental health and addictions sector, as well as partners such as CCACs, long-term-care homes, community support agencies and police. As abused or at-risk seniors have a multiplicity of needs that can't be served by any one of these services, it's important that service providers work together to improve the local response to cases of elder abuse and fill those service gaps.

Lastly, I'd like to talk about our safe medication use seminars. Older adults take up to 40% of all medications prescribed in Canada, and most older adults take several types of medications at a time. When combined with alcohol, some medications can cause harmful interactions. This is of particular significance, given the fact that alcohol is the substance most commonly abused by seniors with substance abuse problems. To date, over 100 educational safe medication use seminars have been delivered across Ontario through a partnership between the secretariat, the Ontario Pharmacists' Association and the United Senior Citizens of Ontario. Through those seminars, we specifically address the interactions and the problems of alcohol abuse.

While these initiatives make a contribution, we know that seniors who struggle with mental health and addictions face a number of challenges that can prevent them from getting the care and support they need. Some of these barriers are unique to seniors, and other barriers are shared by people of all ages. Let me mention a few specifically.

Lack of connection to primary care: Primary care is significant, especially for seniors, because of the complexity of needs that arise with aging. Primary care providers are essential as part of the early identification and intervention process because they're able to form lasting relationships with patients and can observe the changes that occur over time, some of which are very uncharacteristic or very subtle.

In addition, public knowledge and attitudes about mental health and addictions problems have changed rapidly, aided by the expansion of scientific research. This has been a good thing. But we can't assume that older generations have had the same exposure to this change. For generations that pride themselves on their ability to survive hard times through sheer will, mental health and addictions can be seen as personal failures. Lack of knowledge about what mental health and addictions are, or stigma about people who have mental health and addictions problems, can prevent some seniors from seeing their own symptoms clearly and seeking help.

Communication barriers and cultural differences can also affect the ability of a senior to communicate their experience and make them less willing to report symptoms, and may combine with other barriers to prevent diagnosis or cut them off from community supports.

Identifying mental health and addictions problems among seniors is complicated. Seniors' symptoms can be overlooked, and stereotypes about seniors and aging can contribute to under-diagnosis of mental health and addictions problems.

Social isolation can contribute to poor mental health and addictive behaviours, as well as prevent intervention. It cuts seniors off from the people who can identify their issues and trigger a response.

Seniors can face mobility limitations that make them unable to travel independently to places where care and support are provided. They may also live in communities where care and supports are not readily available. These barriers underscore the importance of making services available to seniors where they live.

Due to loss of capacity related to dementia or other illness, combined with the loss of social connections, seniors with mental health and addictions may need additional help to find, organize and access the services they require. For these people, the complexity of the support system itself is a barrier to care.

Elder abuse: Seniors with mental health and addictions problems are more vulnerable to abuse and may be living in situations where they are prevented from seeking help due to physical abuse, threats or intimidation.

Probably the largest barrier is the lack of appropriate housing options. Physical, functional and cognitive impairments related to aging may make seniors a poor fit for residential options developed for the adult population, or they may be functionally well and not require the level of care provided in a long-term-care home. Challenging behaviours like aggression, substance abuse and smoking can contribute to difficulty in accessing adequate and appropriate housing and community services particularly for seniors.

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Beginning on slide 11, we outline some of the specific opportunities to meet seniors' needs. There's no one way to promote seniors' mental health, but there are several key ways that services for seniors can be improved.

First, the use of community-based mental health outreach services and multidisciplinary teams: Seniors benefit from models that facilitate understanding and partnerships among the health care professionals needed to address mental health and the complexity of needs arising from aging. These partnerships include physicians, geriatricians, psychiatrists, nurses, personal support workers, case managers, mental health workers and occupational therapists. These models can also facilitate access to health care services that deal with the whole person, preventing a revolving door between emergency rooms, mental health services or difficulty finding services at all. Services designed to improve community living and coping skills can also be linked up to help support independence.

A focus on early diagnosis and treatment can make a difference for seniors. Training, not just for health professionals but also for the range of front-line community support workers and family members who have direct contact with seniors, would help them better recognize the mental health and addictions problems early. Training and education would also help improve approaches that address cultural differences. Use of specialized assessment tools for seniors would aid in early

diagnosis and help professionals and front-line workers to better distinguish between physical and mental health symptoms.

Affordable and appropriate housing options linked to community services: For seniors with mental health and addictions problems, appropriate and affordable housing is a key to independence and to aging at home. Supportive housing can help seniors have access to the level of physical and psychological care they require so that they're eating healthfully, even if they're not able to organize their own meal preparation, and they have help with the activities of daily living, which often become a challenge later in life. Supportive housing can also link seniors to transportation services that help them maintain good health by ensuring they're able to travel to medical appointments and to the support services they need.

For people who are aging with mental health and addictions issues, particularly those who have had insecure housing in the past, affordable and accessible supportive housing options are of the utmost importance to health and well-being. We also have to ensure that existing services for seniors like Meals on Wheels, many of which are powered by seniors as volunteers, are able to respond to people with mental health and addictions issues.

Finally, research on how to meet the diverse needs of seniors: To ensure we're prepared for the future needs of seniors, we need to know more about how seniors with mental health and addictions problems are being served by the current care and support system. We know there are creative and innovative options out there in our communities; for example, the inner-city access and support pilot program, which is an 18-month pilot program serving homeless and marginalized seniors in the Toronto area. This partnership between the Toronto Central community care access centre, the Homes First Society and others has just begun to improve the care and supports for a vulnerable and marginalized population of shelter users, many of whom experience mental health and addictions problems. The partners recognized that the health and well-being of this group can be improved through more thoughtful and holistic approaches than have been traditionally available. It will be very interesting to see what lessons are learned through this program and what new knowledge can be shared to improve service to these groups.

That brings me to the end of my presentation. I'd like to thank you again for the opportunity to speak with you and will answer any questions.

The Chair (Mr. Kevin Daniel Flynn): Wonderful. Thank you, Diane. Maybe I can start with a brief question, and that is that I seem to be hearing from people in my own community about the increasing problem of seniors developing behavioural issues that may include violence and the inability of the long-term-care facilities to cope with that behavioural issue, and then not knowing where to turn next. Are you seeing that as well?

Ms. Diane McArthur: We are certainly hearing about it. We're working closely with some of the information

providers to understand in more detail what the prevalence rate is. Anecdotally, with the increasing rate of dementias you would expect to see those kinds of problems show up. I think the strain is on the system to find the innovative approaches.

The traditional historical approach to somebody with a dementia was 24-hour, locked-ward care. I think the challenge in the system now is to find more innovative approaches and support systems that allow for care in the community as long as possible.

The Chair (Mr. Kevin Daniel Flynn): Thank you. Any other questions from this side before I move on? Okay. Christine or Sylvia?

Mrs. Christine Elliott: I just have one quick question. One of the things that I encountered in my past life as a practising lawyer was some of the issues relating to people who are maybe in early stages of dementia who are preparing wills and, more particularly, powers of attorney for finances and for health care, but primarily financial. There seems to be a real growing problem. Do you have any particular studies that are under way on that, any collaboration maybe with the Ministry of the Attorney General? Or is that something that's sort of high on your radar screen as well?

Ms. Elizabeth Esteves: We do. We're quite engaged with the Ministry of the Attorney General, in particular, the public guardian and trustee, and also the Ministry of Health and many community organizations like, for example, the Advocacy Centre for the Elderly. The secretariat has actually produced educational materials, our Guide to Advance Care Planning, to assist families and seniors before they lose mental capacity to understand that they can prepare an advance care plan that sets out their wishes for a time when they're no longer capable. Those kinds of educational programs actually have been weaved into our seniors' seminar series, so along with the medication management seminars we do have seminars that talk about those kinds of issues. But you're right; more needs to be done to reach more seniors and families.

Mrs. Christine Elliott: If I could just say, I think also there's a greater need for more legal education on that subject too, because it's very difficult often when you have someone who comes in to see you and you're not really sure whether they're mentally capable of making their own decisions or not but you can certainly see that there may be some influence that's being exerted by family members. So I think it's something that maybe the law society could be helpful with as well.

The Chair (Mr. Kevin Daniel Flynn): France?

M^{me} France Gélinas: Just a general question. I appreciate your presentation and certainly see that you do cut across a lot of ministries and have a positive influence for the seniors of Ontario through the work that you do. Through the work that you do and the partnerships that you share, do you see any shining lights out there, as in groups of people or research under way that could really make a difference as to the growing number of seniors struggling with mental illness?

Ms. Diane McArthur: We tried to highlight one in the presentation. We've been working with some of our partners to try and identify others, particularly the seniors' organizations themselves. There are some very innovative programs; for example, the francophone community has a very informal program that they're working on now, which is Good Neighbours, Bons voisins, which helps people understand and recognize when someone in their immediate community might be at risk and how to help work with a senior in their local community, to provide some of the supports. When it's connected with the rest of the system, it's the early identification and making sure that people know if you think you have someone in your community who's developing a mental illness, who you speak to and how you connect. Those sorts of examples are out there. We haven't really pulled them together in any way; I think they're relatively informal. We are trying to work with the Ministry of Health as well through some of the work that they're doing on a mental health strategy to try and encapsulate some of those.

M^{me} France Gélinas: So there is nobody right now working on best practice for either early identification or treatment or support specifically for seniors—

Interruption.

M^{me} France Gélinas: He'll turn it on for you.

Ms. Elizabeth Esteves: I'm having a problem turning it on.

At a national level there is considerable work under way by the Canadian mental health coalition. There are guidelines on dementia, on delirium. There are lots of wonderful resources. For example, the National Initiative for the Care of the Elderly has also developed guidelines on assessment of particular conditions among seniors. So there are wonderful coalitions of experts.

For example, in Ontario, and I believe that he's on the minister's advisory committee, Dr. Ken Le Clair and many others are involved in this and many physicians that we've developed relationships actually through the Alzheimer's strategy. Dr. Marie-France Rivard is also working at a national level with the working group that is supporting the Mental Health Commission of Canada. There is some work going on at the national level. They'd like to develop a knowledge exchange, a centre of excellence for data and research on mental health, seniors' mental health, and they're also committed to developing a 10-year anti-stigma campaign. There is this wonderful work going on and that will yield lots of new research, so there are key experts working in this field.

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The Chair (Mr. Kevin Daniel Flynn): There's time for one more question. Liz?

Mrs. Liz Sandals: Yes, it just occurs to me that there's a lot of work going on in the area of dementia and Alzheimer's, which makes sense because they're newly acquired diseases for seniors, if you can put it that way. Is there really any work that goes on looking at what happens to somebody who has a mental illness, schizophrenia or bipolar or something like that, and they've had

it for a long time and then they will inevitably age. Has anybody looked at that issue?

Ms. Diane McArthur: There was very little that we could find about that and that's why we think the need for research is so important in this area. The aging of people with mental illness is a relatively recent phenomenon, not unlike the aging of people with special needs, because you used to develop a number of complex other problems in your life course. It's particularly as they get to their much older years and you start to layer on the additional complexities of aging that it's going to become much more difficult, because those people who could self-manage will have additional challenges.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for appearing today.

CENTRE FOR ADDICTION AND MENTAL HEALTH

The Chair (Mr. Kevin Daniel Flynn): Our previous host now becomes the guest. Dr. Garfinkel, if you'd come forward. Thank you very much for the tour the other day. I'm sure it was appreciated by all the members who are seated here. Very interesting, very valuable. Like everybody else, you have 30 minutes. You can use that any way you choose. If you could leave some time at the end for questions, that would be wonderful. The floor is yours. Welcome.

Dr. Paul Garfinkel: Thank you for the opportunity to present my views to this group and thank you for the work that you do on this committee. I've brought with me copies of my submission, the submission that CAMH is making, to assist you in your work. I'll be making a few remarks, I hope few enough to leave you with plenty of time for questions and answers.

I'd like to begin by reflecting on the mandate of this committee. I don't need to tell you that many people are wondering how this committee will intersect with the group that the minister has put together with regard to the mental health and addictions strategy, and we believe there are great opportunities at this time for alignment of these two processes. I, of course, want to focus on the opportunities that this committee has at this time.

Your mandate is appropriately brought. You can look outside the traditional silos of mental health and addiction and how they're funded and you can actively explore all the areas of government, including how well main street government services meet the needs of people who live with a mental illness or a substance abuse problem.

For example, the government has launched an anti-poverty strategy. We welcome these efforts. One key objective of an anti-poverty strategy should be much higher rates of workforce attachment for those with serious mental illness or an addiction.

Another example is the physical health of many of our patients. As you know, as we talked about last week, this can be rather poor. There is about a 65% higher mortality rate from cancer for our patient group than for the Canadian average. Access to primary care is a significant

challenge for many people with mental illness or an addiction, and there are many reasons for this.

The answer to a number of these issues does not lie within traditional mental health and addictions budgets and programs. It relies on ensuring that mainstream health practitioners and programs are sensitive to the needs of people with mental health and addiction problems. Your committee has the breadth in its mandate to explore these issues.

Simply put, this committee's task is very important because mental health and addictions are common, serious and neglected problems. The prevalence of mental illness and addiction, I'm sure you've heard many times, is that at least 20% of us will need some help for these problems at some point in our lives.

In economic terms, mental illness and substance abuse cost Ontario about \$34 billion a year, mostly due to productivity losses but also going through the full spectrum of costs that we experience. Of course, millions of families in Ontario know that the biggest cost can't be measured in dollars and cents. Individuals with these problems know of the shame, loss of control, broken relationships and exclusion. Tragically, these problems are often ignored. Just last year we learned that 65% of Canadians experiencing multiple episodes of psychological distress never did consult a health professional about the problem.

What makes people less likely to seek help for a mental illness or an addiction? Why do I hear patients speak about "entering the mental health and addictions system"? I never hear of anybody entering the "arthritis system" or the "diabetes system"—it doesn't happen. Mental health and addictions are like any other type of human illness, and deserve appropriate attention and appropriate care. The scientific base is strong and the suffering is real.

I believe that the breadth of your mandate and the non-partisan nature of your commitment to improving mental health and addictions care provides you with the scope to address three critical issues.

First, you should acknowledge that many of the key investments that governments make in health don't come from any health budget. Housing, adequate income supports, and access to the labour force are fundamental to the well-being of individuals and fundamental to our system—for every single one of us. Housing is extremely critical for the mental health treatment system, and lack of appropriate housing is one of the greatest impediments chronically ill people face to a full, rich and satisfying life.

We want our hospital beds to be occupied by people who need to be in hospital—people who have complex, specialized needs—for a period of time of the illness. Most people who have an illness don't have to be in hospital for most of the time. Hospital beds can be used well for people who are living in the community, and people have to come back to us for relatively short periods when their illness has flared up. Not only is that better economics—it's cheaper—people have better qual-

ity of lives when they're in the community. There's less loss of identity; there's less dependency; all the problems that hospitals cause can be prevented in the community and you can get just as good care—better care. So that's my first point.

My second point for you to consider is the issue of funding. I'm not here to play a victim and say how poorly we've been treated. We've been treated very well in the last half-dozen or so years, and I also know that this is probably the worst time ever to talk about money in Ontario. Nevertheless, you have to know that for a variety of reasons related to what we've just been talking about, the serious mental illnesses account for about 12% of human distress and suffering. This is data from the World Health Organization. It's true in Canada, it's true in Brazil and it's true in Australia. It uses a global burden of disease to measure disability; it looks at early death or lack of productivity and the burden that you experience. So five out of the 10 top causes of disability are in our sector, whether it's depression, schizophrenia, OCD, alcohol—five out of the top 10. They account for 12% of disability. Our funding is always about 5% to 5.5% of the provincial health budget. Even with the gains that we've made in recent years, we're about 5.4%.

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Most OECD countries devote a considerably greater percentage of health care dollars to mental health, including the UK, the USA, Germany and Australia. We're way back. Within Canada, Ontario's spending for mental health trails the national average: On total per capita spending across the provinces, we are ninth. Clearly, we're confronted in this country and this province with an enormous gap between the size of the problem and the health care response.

There are no magic solutions to addressing this gap. Government has made important investments in community mental health care in the last six, seven years that I think are amazing. I never would have thought I would see the kinds of investments made and how they're used so well. You heard last week from my colleague Paula Goering that these investments are being rigorously evaluated to ensure they're building a better system. The government is to be congratulated both for the investment and for assessing the impact of these new developments, yet the gaps in treatment remain significant.

This committee represents a non-partisan commitment to addressing mental health and addictions care in Ontario, and ought to be establishing long-term objectives to building a stronger system of care. We would all be greatly enhanced if there were goals that were clearly defined over the coming decade.

The committee should also consider establishing an objective of systematically increasing investments in mental health and addictions care, particularly in the community sector. So you'll have a hospital coming to you saying, "Invest in the community," particularly community supports, social supports and housing.

In keeping with these new investments, there should be evaluation of every step of every development, so that

we can be clear that the funding is appropriately being used, that people who need the funding and need the new treatments are getting them. This has not always been the case in our province.

The third thing I wanted to just comment on is that I'd ask you to look at the issue of primary care. Family doctors, community nurses—these are the people who are most often consulted by people seeking help for a mental illness or an addiction, and that's the way it should be. Some 80% of the work in our sector will continue to be done by the primary care. We want that.

We must remember that the health needs of people with mental health and addictions problems are the same as the health needs of people throughout Ontario. Early recognition is important; identification of emerging problems is important; prompt and respectful referral to more specialized services, without stigma or embarrassment; and ongoing support to assist the person to take greater control of their health and their lives. We can do an awful lot more in this arena.

Unfortunately, there is evidence that the ability of primary care to provide mental health and addictions treatment that conforms to guidelines and best practices is often limited. I think last week I gave you the data from Ontario that said for an eminently treatable disease, depression, half of people in Ontario won't get treatment. They won't come for treatment, or it won't be recognized as a problem of depression. Even as alarming is that of the half who come forward, one half of those won't get the best practice, will be inadequately treated—and that's as true for urban Ontario as it is for rural Ontario.

Research points to many solutions here. It emphasizes the multidisciplinary team and better patient follow-up, which haven't always been optimal in our province. The Ministry of Health and Long-Term Care is headed in the right direction with the expansion of community health centres and community health teams. We should be assessing whether these investments have been successful in improving mental health and addictions care and outcomes. We should also be assessing whether these mental health and addictions problems are getting better access throughout our primary care system.

We have to learn how better to help our primary practitioners. This is a responsibility that CAMH takes very seriously. We are connected to many family practices across the province, and we provide continuing updates in a highly valued way so that people can learn about health promotion, and prevention, early identification and treatment of common mental illnesses.

I'd like to just end with a note about CAMH and its role in the system. Eleven and a half years ago, we were created when the HSRC amalgamated four institutions: the Donwood, the Addiction Research Foundation, the Clark Institute of Psychiatry, and the Queen Street Mental Health Centre. I've had the privilege of serving as president and CEO of CAMH throughout its history, and I'll be leaving this post in a number of months. I'm very, very proud of what we've accomplished at CAMH, and I think Ontario can also be proud. We've successfully

brought together the treatment of mental health problems and addictions problems, and we've improved services for large numbers of our patients who have both a mental illness and an addiction. CAMH is the largest mental health and addictions hospital in the country, one of the very large ones in the world. We can make a huge difference in the lives of people throughout the province, whether it's by fly-in service, teaching, building capacity, or telemedicine.

Depression is one example where we make a very significant difference. Just a few blocks away from here, you'll find the most sophisticated brain imaging centre in the country and the best in the world. The researchers in our PET centre have had significant impact on best practices, new medications in treating depression, and in fact understanding the role of psychotherapy as it plays on the brain. Our basic science has provided a whole new understanding of how the brain works, leading to new and innovative treatments. A lot of this has occurred just in the last three years, and it's quite thrilling to us. At the same time, our health promotion specialists are looking at how you can prevent the fall in self-esteem that occurs in adolescence, how you can prevent depression, how you can recognize it earlier, and, if someone is troubled by depression, how you can live a full life in Canada in all aspects.

The work of this committee can also be an important milestone in building a healthier Ontario. With a focus on long-term funding commitments and social investments that support health and primary care, you can bring a pan-government perspective that is needed to make a sustainable difference in the lives of so many people who have mental illnesses and addictions. We welcome any opportunity to support you in your work. Please don't hesitate to call us if you have any questions or need for anything from our point of view to help.

1820

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for your presentation. Let's start with this side this time, either Christine or Sylvia.

Ms. Sylvia Jones: Just very briefly, I wanted to get you to expand more on the role of the primary care physician. You mentioned 80% of the work will be done by primary care providers. If you had a number one wish list, what would be the best way to either educate, inform—get buy-in, basically?

Dr. Paul Garfinkel: Could I have three number ones?

Ms. Sylvia Jones: Absolutely. You're leaving.

Dr. Paul Garfinkel: I think our universities, our medical schools and our health disciplines training have very recently gone into inter-professional education. I see that as hugely important. The way physicians have been trained—sometimes selected and trained—works against building effective teams, and I can't tell you how important teamwork is in everything we do in health care. It's true in much of life these days. But you can't do in health care or in health care research without effective teams, and you can't make the doctor the prima donna and expect an effective team. That's the first thing I'd say.

The second thing is that physicians need, in the primary care setting, an awful lot of education support, but not in the traditional way where you go to a conference and you come back. Those are very good for motivation; they make you want to know more and read more, but what you need is ongoing help when you have a clinical problem. We need to evolve shared care models. Say, a family health team has access to our depression specialists on Fridays, and you connect by the phone, by web, by TV, as the person's in their office—or we're out there every Friday.

Those two are critically important. I would add a reconsideration of OHIP funding models. As I understand it, the family health teams are really addressing that. A good primary care doctor can spend six or seven minutes with a patient, and how can you do good care in that time allotment? That has a lot to do with how OHIP reimburses primary docs. I do think there's a lot the multi-disciplinary team does, but I think you want physicians to be well funded for sitting and being with people. As you all know, it's very important to be able to sit with somebody who is very ill or disturbed and just be with them, not sitting and staring at, "Is it six minutes or seven minutes?"

So those are my three.

Ms. Sylvia Jones: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you. Speaking of six minutes, France, it's your turn.

M^{me} France Gélinas: I'm pleased to see you again. I was most interested by some of your solutions for primary care and certainly support them wholeheartedly. I was also intrigued by—you gave that 50% of the people with depression won't get recognized and therefore, won't get treatment, and of that 50% who comes, they won't get the right treatment. Could you expand on this? Let's start with the first 50% who will never come. How come, and what can we do to change this? And then the next question will be, for the 50% who do come, how come they get the wrong treatment?

Dr. Paul Garfinkel: The 50% who don't come, don't come for a variety of reasons. They can be embarrassed. They can feel it's a moral problem: "I should pull up my socks and solve it myself." They can feel, "It'll hurt my career." They can be from some groupings in our society who feel hugely embarrassed related to the marriageability of others in the family: "If I have a serious illness, what does that mean for my brothers and sisters and who's going to want to marry them?" So, many people don't come.

If they do come for treatment, it may not be recognized. The primary doc may see it as a physical problem. Many people in our society present with depression with physical symptoms: "I can't sleep. My gut hurts, I can't move my bowels. I'm twitchy"—and you could go on to a very lengthy series of investigations rather than the right treatment. Or sometimes, a family doctor or a primary care worker is not comfortable in this arena and won't ask the right questions, or will ask the questions in a distorted way. Your family doctor says to you, "You're a moderate drinker, right?" It's very hard to say, "No,

I'm a heavy drinker." It has a moralistic tone. In spite of that, 80% of people who go to the primary care person for help respond to say, "This is a very positive experience."

When you come for help for depression in Ontario—before, I was talking about any kind of primary care; now I'm talking about a family doctor—chances are very heavy that they'll put you on an antidepressant, and because of perhaps worries about side effects or a lack of familiarity, they will put you on a very tiny dose, not enough to have the proper benefit. The antidepressant drugs we use are effective in about 80% of people when they're used with counselling and when they're used in the right dose.

We have a very busy clinic for mood disorders that does consults. There are many consults a week. The most common response is just to increase the treatments. So it makes you wonder, "Why do our specialists have to do this? Is there not another way to connect to the family doctor?"

In addition, there are some newer forms of psychological treatment. They're focal treatments; they're not the long, extended treatments that may last 20 weeks. They're really effective for depression and anxiety. Here the issue is, how do you teach people them when they've been out in practice and how do you have practitioners spend the time that's necessary to do so? Again, we do teaching for thousands of people a year in primary care. They rate it highly; they love it. Sometimes, outside of family health teams, it's hard for them to be able to do what they have to do and earn a living.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Dr. Garfinkel. We've got Helena and then Liz.

Ms. Helena Jaczek: Very much on the same theme about the 80% who have that primary contact with the primary care physician—we did talk a little bit about this when we were visiting your facility. What is CAMH doing in terms of helping family physicians to make the diagnosis—this whole issue of early recognition—given that, clearly, there may be physical symptoms that distract you and you have a broad differential diagnosis and so on.

It seems to me that the average family physician with the six minutes needs some sort of tool that they can use as soon as they have a suspicion that perhaps there's an ill mental health component to this presenting situation, that they have an easy way, somehow, of being able to recognize—so that's my first question: What are you doing in terms of helping, given the research you've done? And second, there will always be many family physicians who will not feel able to spend the time and explore in more depth and really have the ability to know what's out there in terms of supportive housing and so on. So could you give us a recommendation, if that physician is not on a family health team and is in solo practice, for where they go from that diagnosis to making an effective referral?

1830

Dr. Paul Garfinkel: Good points, and they cover the two ends of the spectrum. The housing is, by and large,

for chronic, serious illness, and I don't expect any regular doctors—and maybe many community psychiatrists—to know the details of different types of housing. This is an area that has a real science to it now. When we went to school, everybody went from the hospital, if they were lucky, to a crummy rooming house. Now there is supportive housing, which makes a huge difference in re-admission to hospital. So I would expect them to connect with specialists in the area of chronic illness, who, by and large, are in the specialty hospitals in Ontario.

The other part of your question about the front end relates to many of the things I mentioned in the previous question. We have to see that the medical schools, the nursing schools and the social work schools give adequate time and information, that people feel comfortable with these. We have a real obligation when teaching people in undergrad, teaching the residents. We have a set-up with about 82 primary care docs right now as a base to get into this more. We have to do a better job of getting people access when the doc is worried. I might see somebody in consult—it might take me two or three weeks. I say, "Let's try this and this, and then send them back." If the person is really having trouble, I should be able to take them back very quickly. Otherwise, the family doctor feels burned. We have some work to do on that.

In my own area of, say, anorexia nervosa, when people are improved and stable, I do find the primary care docs very accommodating. But things can go bad very quickly, and if you can't see the person in 24 hours, they won't take the next person. And they're right not to.

The Chair (Mr. Kevin Daniel Flynn): There's time for one very short question and one very short answer—or maybe one long question and no answer.

Liz.

Mrs. Liz Sandals: You've noted in the materials that you gave us that there's often an overlap, a dual diagnosis, between people with particularly serious personality disorders and addiction, but we tend to organize the mental health system around, "Here's mental health and here's addiction." Do you have any particular recommendations on how we can break down those silos and integrate the treatment.

Dr. Paul Garfinkel: Yes. In 1989, I was at Toronto General and we had about 40 psychiatrists on staff—this is going to be a long answer; sorry. We had 40 psychiatrists on staff, 25% of our referrals were for an addiction-related problem, and we had nobody with a clinical ability in addictions and nobody who could teach the students about it. So for the last 12 years, we've been working hard to break down those silos. Twenty per cent of the people at CAMH now have cross-program connections. The figure should be 40%.

Mrs. Liz Sandals: But what you're really saying is that that's a deliberate hiring and training strategy as opposed to—it isn't so much that the government said, "Thou shalt integrate," it's actually, at the local agency level, deliberate hiring and training.

Dr. Paul Garfinkel: This is clinical idealism that turned poorly about 40 or 50 years ago, in which there

was a split, particularly in North America. The addictions community did not have a common view. They hated the pathologizing and the moralizing of the mental health community, and the self-help movement was very successful, so they just split off. It had nothing to do with patients. Patients readily get—you need to help them both.

The Chair (Mr. Kevin Daniel Flynn): Thank you for being here today.

Dr. Paul Garfinkel: My pleasure.

The Chair (Mr. Kevin Daniel Flynn): I'm not sure if I should thank you for the news that you'll be leaving us soon. That was a bit of a surprise.

Dr. Paul Garfinkel: It's time.

The Chair (Mr. Kevin Daniel Flynn): My first thought is, if we can't quit, you can't quit.

Laughter.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for being here today.

CHILDREN'S MENTAL HEALTH ONTARIO

The Chair (Mr. Kevin Daniel Flynn): Our next presenter, our final presenter of the day, has arrived with perfect timing: Gordon Floyd, executive director of Children's Mental Health Ontario. If you'd like to come forward, Mr. Floyd, the floor is all yours. As with the previous delegations, you've got 30 minutes. You can use that any way you see fit, but if you could leave a little bit of time at the end for some questions, I know that the members would appreciate that.

Mr. Gordon Floyd: I will certainly try to do that. Thanks, Mr. Chair.

I really do appreciate this opportunity. I know you have had a long day. My guess is, everybody wants to get away to dinner. I'll try not to hold you up too much. I will try to keep my opening remarks reasonably brief so that I can deal with your questions and talk about the things you want to talk about.

I am the executive director of Children's Mental Health Ontario. We're an association that was established in 1972. Our mission is to champion the right of every child and youth in Ontario to mental health and well-being.

Our core membership consists of about 85 accredited children's mental health centres. They are spread across the province. There are about 32 of them in the GTA. In most parts of the province, in most counties, in most districts, in most regions, there is only one accredited children's mental health centre.

Most of those agencies are multi-service agencies. I know that you have heard a fair bit, and you will hear more from me, about the need to integrate services in many ways. One of the interesting things that I have learned is that at the community level, there is a very great degree of service integration already going on. Approximately 70% of our accredited members are multi-service agencies. Some of them combine with youth justice agencies; some of them combine with children's aid societies;

some of them combine with adult mental health services; some of them combine with women's shelters—it's quite an array of services.

We also have, in our membership, a range of other child and youth mental health service providers, not accredited—that's a smaller number—and we include as well in our membership a number of individuals, parents and clinicians.

Our key activities, besides being an accrediting body, include work in the areas of public education about children's mental health—anti-stigma work. We also provide significant support to service providers in the implementation of evidence-based practice and the improvement of their services in that way.

On behalf of the Ministry of Children and Youth Services, we provide training and management related to the mandated intake tool, screening tool, that's used across the system. It's called the brief child and family phone interview, BCFPI. We have also worked very closely with the ministry on policy development initiatives. We played a very strong partnering role with the ministry in the development of the policy framework for children's mental health that appeared about a year and a half ago, called A Shared Responsibility.

Some of you will know us in our other role, which is as advocates, and advocates in particular in relation to the funding of services and the capacity of the children's mental health system.

In our public education work, we focus most of our messages on three themes. The first is one that I expect many of you are familiar with, and that is that one in five children in Ontario has a diagnosable mental illness. We use this theme, and hit on this one first, in large measure to help de-stigmatize children's mental health problems. The significance of one in five children being affected is that essentially every family in the province has some direct connection to a child with a mental health problem. Certainly every classroom is affected; in a typical classroom, there will be four or five children who are struggling with some type of a mental health difficulty, and most certainly every community is dealing with these problems.

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In our public education work, we also emphasize that children's mental health problems are serious. They're not to be dismissed. Many people of my generation have the attitude that a kid who's having a bad day probably just needs a kick in the butt and all will be right. We make the point repeatedly that children's mental health problems are extremely serious and, when untreated, far too often lead to very serious consequences such as suicide. I know that Senator Kirby last week was talking to you about some of the suicide statistics, and I won't go into those again.

The third message that we emphasize is that treatment works. The mythology that is still prevalent, that mental health problems are not treatable, is just that: It's mythology—particularly when you're dealing with children and particularly when you're able to intervene early. The

wonderful thing about working in the children's mental health field is the realization that you're still dealing with developing brains, you're still dealing with problems that are in their infancy, that haven't taken deep root, and it is most often possible to overcome those problems by intervening early with effective, evidence-based treatments.

The messages that you may have heard from us more often are some of our advocacy messages. I'm not going to go into those in detail, but I'm going to touch on them lightly because they are critical, I believe. The first of those is that our existing system of services for children and youth with mental health problems and their families is inadequate to meet the needs. It is unable to meet the needs of children and families in this province, and the gap in that regard is getting wider and wider.

I have provided you—yes, the clerk has had a chance to get this to you—with a two-page paper that summarizes what's happening in 10 children's mental health agencies around the province. I didn't pick the 10 worst; I picked 10 typical agencies in all parts of the province to put into this document. What you will see there is that agencies are chronically running deficits. Agencies are systematically, year after year, cutting back services, laying off staff. They are, year after year, raising the bar for admission to their services so that they're increasingly becoming crisis-based services and they are, in many respects, falling further and further behind.

I know that all of you are aware of the crisis that emerged a few weeks ago at the Roberts/Smart Centre in Ottawa, where the board began the process of heading to bankruptcy. You may not be as aware that earlier this year in Hamilton, the Community Adolescent Network folded its doors due to insolvency. What you definitely will not be aware of, but must be aware of, is that these two agencies are the canaries in the coal mine.

I am not one to use the word "crisis" lightly. I don't like the word because it is so overused. I'm not one to sound alarmist, but I will tell you that there is absolutely no doubt that what we have seen with the Community Adolescent Network and the Roberts/Smart network is going to be repeated many times over in the next couple of years. Across the province, agencies truly are hitting the wall. Today, I heard from one agency where again this year, after they did their union negotiations, they've had to lay off another couple of staff and cut services by that much more. I heard from an executive director who was almost in tears this morning. She has only been in her agency for eight months and she realizes that her budget is heading for a \$500,000 deficit this year. She has absolutely no money in her budget to train her staff about the implementation of evidence-based practices. She really does not know whether her agency is going to be able to survive. That's an agency here in Toronto. There are other examples in the material that I've provided you with.

The reason for this lack of capacity is quite simple: In 12 of the last 15 years, there were no funding increases of any kind for children's mental health services. During that period, the system lost, just by inflation alone, about

25% of its capacity. What has been happening at the same time as the system has been losing its capacity is that the demand for children's mental health services has been steadily rising. That's for a whole lot of logical reasons that we all know. We know about the changes that have happened in family life, in the structure of families, in the last 20 or 30 years. We know about the increased pressures that young people are feeling through the media, through the need to excel at school, through the need to keep up with their peers. We also know that, fortunately, we're doing a better job of recognizing behaviour and emotional problems for what they are, so more children are being referred for service at the same time as we have less and less capacity to meet their needs.

As I mentioned earlier, services are remarkably well coordinated at the local level. The coordination in most instances is pretty informal. If you go to a place like Lanark county, there's one children's mental health centre, there's one children's aid society, there's one family service organization, there's one developmental disabilities organization, and they all talk—they case-manage situations on a weekly basis and the coordination at the community level happens all the time.

Where there is no coordination or very little coordination is across ministries and at the policy level. In particular, here in Ontario we have, in truth, three different children's mental health systems that don't connect very well. We have the community-based system, which is the one that I'm most involved with. That's a system where services are delivered through transfer payment agencies. We have a school-based mental health system, which is pretty anemic, but it's important. The psychological services and the support services that are available through the schools are geared to help children who have learning problems, and rightly so. But the link between those services and the community-based services is very ad hoc and very, very weak; truly inadequate. Then we have a whole other set of services that exist in the health system. Some of those are hospital-based services such as the crisis stabilization that happens when a child's having a psychotic episode, or the eating disorder clinic, which is essential to providing the intensive care that children with those problems need.

1850

We also have within the health system what is probably the most used and least equipped part of our children's mental health system, which is the part that happens in family physicians' offices. Family physicians in this province get no training at all in children's mental health. We have been told by the Canadian Paediatric Society that half of all visits to pediatricians in this province are for mental health problems. We know that family physicians are constantly dealing with these issues. They don't have the training. They don't have the time. They certainly are not compensated in a way that they can spend an hour doing cognitive behavioural therapy with a child who needs that, so they pull out their prescription pad and write a prescription, usually for drugs that have never even been tested on children.

The only drugs in the field of mental health that have been tested on children are those for ADHD, and yet on a constant basis we are writing prescriptions for antidepressants, anti-psychotics and a whole host of other pharmaceuticals without having any understanding of what the long-term effect is going to be on the brains of the children that are processing them. Everything that happens in those physicians' offices is disconnected from what's happening in the schools and from what's happening in the community-based agencies.

We have a very serious problem, and I think that there is a serious issue to be addressed about the organization of children's mental health services in Ontario. There are probably many ways to look at this, but the question that keeps popping into my mind is whether it makes sense for us to have a single children's mental health system, a set of services, if you like, that moves in and out of various systems, or whether we want to maintain three separate systems and try to figure out ways to connect them better. I think that that's a fundamental decision that needs to be made and that I hope your committee will wrestle with.

I guess what's implicit in much of what I'm saying is that system reform is urgently needed in the child and youth mental health services area. We are fortunate in Ontario that we, for the last year and a half, have had a really good map for what the system reform should look like, and that map is set out in the policy framework, *A Shared Responsibility*, that was produced by the Ministry of Children and Youth Services a year and a half ago, in November 2007.

Unfortunately, in the time since that policy framework was issued, there has been no visible movement on its implementation. If you haven't already heard from the ministry, I'm sure you will that they have a mapping exercise under way and that they're trying to get a sense of where services exist, and that's great. In the meantime, we're trying to run agencies and we've got kids coming to our door and nothing has changed in the 18 months since that policy framework appeared.

The recommendations in that report, the way forward that's set out in that policy framework, really make good sense. The contents were developed after extensive consultation with people in all of those systems that I talked about a moment ago, and there is strong buy-in to the direction that's laid out in *A Shared Responsibility*.

The key points there, as we understand them, are quite closely related to the five points that are laid out on that page you've got in front of you, the five things that kids and their families need. We need a front end to our children's mental health system. We need a system that does something other than or more than deal with crisis situations. We need a front end that includes health promotion, illness prevention and early identification. We don't have any of those pieces in places in a comprehensive way in Ontario today.

We don't engage public health. We don't engage the Ministry of Health Promotion. We don't engage our schools, our Best Start agencies or our other early

childhood facilities in any systematic program to screen for potential mental health problems. We screen newborns for 26 different physical health problems. We have nine—I believe it's six or nine—mandatory vaccinations, yet we don't have any universal programs for either prevention or identification in the mental health sphere.

A second key plank or part of the policy framework speaks about the need for more timeliness in terms of services. I'm sure that you have all heard at various times about the long wait-lists and the long wait-times for children's mental health services. In 2008, the average wait-time to start service in a children's mental health centre in Ontario was 69 days. There were 1,716 children who waited longer than six months to get into service in 2008. That's 10% of all the kids who got into service waiting longer than six months. In any other field of health, that would be readily recognized as completely unacceptable.

A third piece in the policy framework which we, again, strongly support—I guess what I will say about the timeliness, before I leave that, is that there's no way that we're going to achieve greater timeliness, easier access to services without putting more resources into the system. This is the burning platform at the moment, and I want to make it very clear that we strongly support the medium-term and longer-term initiatives that need to be taken to reform and fix the system. We are not talking about maintaining the system as it is and just putting more money in to keep doing the things that are being done now.

At the same time, I cannot emphasize strongly enough that it is not good enough to say that we have a 10-year implementation plan under way for a policy framework and to continue to freeze funding while that 10 years is playing out. We are not able to meet the needs of children today. Agencies have reorganized their services; they've gone from single counselling to group counselling; they have merged across the province—most of our member agencies are mergers—and they have stripped out all of their management capacity, to a point that is dangerous, as the Auditor General noted in his report. Agencies have truly cut to the bone, and it simply is not good enough to say, "Hey, we've got a mapping exercise under way. We've got a policy framework that we're going to implement, and once we've got a better case in place for funding services, then there will be more funding." By then, we won't have very many agencies left.

I will move on, very quickly. I've just a couple of more quick points.

Again, linking back to the policy framework, the framework calls for more collaboration across systems. I have already said to you that there is some good collaboration happening at the community level, but the real place where collaboration is needed is at the ministry and policy level.

The framework talks about eliminating gaps, the need to eliminate gaps in services, particularly in rural areas and northern parts of the province. We certainly see that those gaps exist and strongly support that aspect of the framework.

And finally, the framework talks about the need for more use of research-based practices and outcomes evaluation; in other words, better services, more effective services. I'm very proud of the work that goes on in child and youth mental health agencies, but there's no question that the science in this field has gotten far ahead of the practice. There have been very, very exciting discoveries, innovations and research findings over the last 15 years, and very few of them have been implemented in our system in Ontario. There simply is no capacity to do that implementation. Nobody has the time or the room to send their staff off for training, like that agency that I referred to earlier, where I got the call from the ED today.

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In some ways, the slow movement in the implementation of evidence-based practice in Ontario is one of the things that frustrates me the most. We have, at Children's Mental Health Ontario, frankly decided to stop waiting for the government and the ministry to get on with the implementation of evidence-based practices, and we have now launched several communities of practice for knowledge exchange around implementation of various kinds of evidence-based practices, because the ministry's not doing anything in this regard. It is showing no particular interest, to date, in doing anything in this regard.

The one piece that the ministry has been supporting that is very valuable, that relates to evidence-based practices, is through the provincial centre of excellence at CHEO, which is very strongly supporting agencies in their work to evaluate their outcomes. Of course, if we're to have an evidence-based system, it has to be a system where we have the kinds of feedback loops that will allow agencies to know how well their services are doing when they're delivered, so evaluation is a very important part.

I don't want to overlook the important work that is being supported by the ministry in terms of outcomes evaluation, but in terms of enabling agencies to develop the systems and protocols and to train their staff and the rest of it, to actually be able to deliver evidence-based practices, it's not going on there. So we have, together with others, been taking our own initiative in that area.

So I guess I will leave it at that. I think I've made my key point for the opening, and I hope I've left a little bit of time for your questions.

The Chair (Mr. Kevin Daniel Flynn): Unfortunately you haven't, but we could each take a minute. I mean, the gentleman's come here. It's entirely up to the committee.

Mr. Bas Balkissoon: One question each.

The Chair (Mr. Kevin Daniel Flynn): One very brief question from each, perhaps starting with France?

M^{me} France Gélinas: I can sense the urgency in your field of children's mental health. Things are not doing well, and the demand for your services keeps escalating. Just a quick question from me: The ministry presented today, and they talked about 373 transfer payment agencies providing children's mental health services, yet your agency talks more about 100 and some. Where's the disconnect here?

Mr. Gordon Floyd: Most of the difference is made up by small agencies that are being funded to deliver one or two programs. So there are only about 90 to 100 full-blown, if you like, children's mental health centres in the province. Dollars are flowing to many more agencies to deliver a specific program to a specific population.

The big concern with that is that there are only 125 agencies in the province that are using BCFPI—the brief child and family phone interview—which is the common screening tool, and the same 125 agencies are the only ones that are using the CAFAS tool, the child and adolescent functional assessment scale, which is the outcomes measurement tool. Since the other agencies aren't using it, we really don't know who they're taking into service and we don't know what the outcomes of their services are.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Mr. Floyd. Helena?

Ms. Helena Jaczek: No, I will defer to Liz.

The Chair (Mr. Kevin Daniel Flynn): Liz?

Mrs. Liz Sandals: This is actually a follow-up on what you just said because—we've got some public accounts training here that is coming through. It's our understanding that many of the agencies, as you said, that are being funded are not actually accredited. I wonder if you could talk to us about, what does an accredited children's mental health agency look like and what are the qualifications that agency has to get accredited, as distinct from some of the other agencies?

Mr. Gordon Floyd: Sure. The accreditation program, which was developed initially about 20 years ago, requires agencies to be measured against over 300 different standards. A number of those standards are about general agency management, so they're about governance, financial management and the like, but most of the standards and the ones that are most relevant in this context are what we call program standards. Those cover everything from the way in which you put together and maintain a client's file to the way in which you involve various types of professionals in assessing the child and meeting the child's needs, and it goes on.

The children's mental health accreditation standards are really the only place where good practice in the delivery of children's mental health services is laid out. The ministry's regulation is limited to the provision of residential services and it mostly relates to the size of the window, the safety of the accommodation and the staffing ratio. Over 90% of the children who are seen in our children's mental health system are seen on an outpatient basis, or a day treatment basis, so those residential regulations are not relevant to them.

I would be happy to provide the committee with the full book of standards, if it would be helpful.

Mrs. Liz Sandals: It would actually perhaps be—at least the executive summary, or whatever is easy for us all to have, so if you were to submit that to the clerk, because I think this will become relevant to our discussion, thinking about accreditation and evidence-based programming and those sorts of things. I think that would be helpful information.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Liz. The last word to you, Sylvia.

Ms. Sylvia Jones: It's going to be hard to pick one. I appreciate your candour this afternoon. I'm trying to square the circle with, we had children and youth services in and they were talking about some of the preliminary results that have come from their mapping exercise. They made reference to an average wait of 38 days for children and youth, and yet you made reference to 69 days and upwards to six months. Where's that disconnect coming from? Because quite frankly, your numbers are closer to what I experience in my communities.

Mr. Gordon Floyd: Yes. The 38 days is the average wait time for those who were admitted. That 38-day figure—

Ms. Sylvia Jones: So it's almost a crisis.

Mr. Gordon Floyd: —does not include the children who came looking for service and were still waiting for service at the end of the year. The 69-day figure includes all the children.

Ms. Sylvia Jones: Which, as you pointed out, because most services are not provided in a residential setting, would be the majority.

Mr. Gordon Floyd: Yes. That would be a majority.

Ms. Sylvia Jones: Your 69 would be the majority of people seeking services.

Mr. Gordon Floyd: Absolutely, yes.

Ms. Sylvia Jones: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you. Perhaps I can ask one question. A lot of your presentation was about funding. Just so I understand this: You said that out of the last 15 years, in 12 of those years the agencies have not received any increase at all. That would stress, I think, any organization.

Mr. Gordon Floyd: Yes.

The Chair (Mr. Kevin Daniel Flynn): We can understand that would stress them. How long has that been going on? Presumably in three years they did receive increases.

Mr. Gordon Floyd: Yes.

The Chair (Mr. Kevin Daniel Flynn): Do you know which years they were?

Mr. Gordon Floyd: Yes. They were 2004—some of that increase was bumped up, so I'm counting 2005 as being a year of increase, and 2007. The three increases have all happened in the life of the current government, but there were no increases in 2006, 2008 or 2009.

The Chair (Mr. Kevin Daniel Flynn): Okay. Thank you very much. That is some interesting information. Like Sylvia, thank you for your frankness.

Mr. Gordon Floyd: Sorry to have gone on for so long.

The Chair (Mr. Kevin Daniel Flynn): No, you didn't go on at all. It's your 30 minutes. I think you generated a lot of questions. We've got some time to work on this.

Mr. Gordon Floyd: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you for coming.

We're adjourned.

The committee adjourned at 1907.





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MH-10

MH-10

ISSN 1918-9613

Legislative Assembly of Ontario

First Session, 39th Parliament

Assemblée législative de l'Ontario

Première session, 39^e législature

Official Report of Debates (Hansard)

Monday 15 June 2009

Journal des débats (Hansard)

Lundi 15 juin 2009



Select Committee on Mental Health and Addictions

Mental health and addictions
strategy

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Stratégie sur la santé mentale et
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Room 500, West Wing, Legislative Building
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Telephone 416-325-7400; fax 416-325-7430
Published by the Legislative Assembly of Ontario



Service du Journal des débats et d'interprétation
Salle 500, aile ouest, Édifice du Parlement
111, rue Wellesley ouest, Queen's Park
Toronto ON M7A 1A2
Téléphone, 416-325-7400; télécopieur, 416-325-7430
Publié par l'Assemblée législative de l'Ontario

LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

SELECT COMMITTEE ON
MENTAL HEALTH AND ADDICTIONSCOMITÉ SPÉCIAL DE LA SANTÉ
MENTALE ET DES DÉPENDANCES

Monday 15 June 2009

Lundi 15 juin 2009

The committee met at 0902 in the Hilton Hotel, Windsor.

MENTAL HEALTH AND ADDICTIONS
STRATEGY

The Chair (Mr. Kevin Daniel Flynn): Ladies and gentlemen, thank you very much for your patience, those of you who arrived a few minutes early. One side of the committee is here, and I know the other half of the committee is just coming in the door. Some other people have been held up—unfortunately, their planes are late—but we're going to kick it off.

HOUSE OF SOPHROSYLE

The Chair (Mr. Kevin Daniel Flynn): Maybe we can ask the first delegation to come forward: the House of—Sophrosyne?

Ms. Deborah Gatenby: Sophrosyne.

The Chair (Mr. Kevin Daniel Flynn): I knew I'd get that wrong. Whichever one I said, it would be the other one.

Thank you very much for coming forward, Deborah. If you'd like to just make yourself comfortable. What we've been doing with the delegations is that everybody has been getting 30 minutes—

The Clerk of the Committee (Ms. Susan Sourial): Twenty minutes.

The Chair (Mr. Kevin Daniel Flynn): Oh, 20 minutes; I'm sorry, yes. You can use that any way you see fit. If you could leave a little bit of time near the end, that would be great. If you would introduce yourself for Hansard at the start of your presentation, and other than that, the floor is all yours. Welcome.

Ms. Deborah Gatenby: Does everybody have a copy of my handout? Because I'm going to take you through it.

The Chair (Mr. Kevin Daniel Flynn): I'm sure we do.

Ms. Deborah Gatenby: Good morning, everyone. It's such a pleasure to be here and meet with you this morning.

House of Sophrosyne: I'll start out by telling you where the name comes from. Sophrosyne was the Greek goddess of moderation. It means a wise and balanced life, and Plato speaks of her in his work *The Republic*. That

philosophy of knowing yourself underpins everything that we do. We're a women's alcohol and drug treatment facility. We've existed in this community—we celebrated 30 years last year, and a woman doesn't know herself till she's 30, so we're very proud of that.

I'm going to take you very quickly through a little foundational piece: how women are different from men in terms of becoming addicted; consequences; shame and stigma; physical and sexual abuse equalling trauma experience for women; and treatment and systemic issues. That takes you to page 3.

Women metabolize alcohol and drugs differently than men because their bodies contain less water and more fatty tissue, so substances are less diluted in our bloodstream and we keep them in our bodies longer. We also have decreased activity of an enzyme that breaks down alcohol. Estrogen affects our metabolism. We become dependent on substances more quickly and use less of a substance before becoming dependent. On average, women abuse alcohol and drugs three times longer than men before they come to treatment, so they are much more ill when they arrive for us to treat them. Women are five times more likely to have been sexually abused as a child. Women suffer greater physical, interpersonal and legal—especially child welfare involvement—consequences and financial stigma as a result of their substance abuse. And pregnant and parenting women—you know, the notion of motherhood or being expectant and also being dependent is quite stigmatized.

The entire addiction treatment system was designed over 50 years ago for the male alcoholic. In fact, our own centre was designed for the sort of stereotypical kitchen drunk, the housewife with the bottle of vodka tucked into the ironing basket. We don't see her anymore. She doesn't exist. The women we treat are much more complex, and, by and large, predominantly are addicted to pharmaceuticals. Pain relievers and benzodiazepines are the most common things that we're seeing.

Over the past three decades, the treatment of women has evolved, and we categorize these into three evolutionary periods.

The first is gender-specific—and some coeducational treatment providers haven't even made this leap. That means that women represent at least one third of the client population in a coeducational facility, they're treated separately from the men, and special groups and

services are added on to the treatment program that was originally designed for the male alcoholic.

Page 5 is the second evolution, and this is gender-informed. You'll see the shocking photograph, which my next colleague, I'm sure, will speak to a little bit more. This is one of the fashion models who was banned at the Rio show. The program is designed to recognize the distinct differences in women's treatment and health needs. It's a feminist/empowerment model: all-female staff; flexible length of stay—best practices are up to 35 days; child care is made available, because women come with children; integrated eating disorder programming, family systems, and harm reduction.

The third evolution, which is the evolution that I'm dwelling in right now as a service provider, is trauma-informed and integrated treatment: relational theory; strengths-based leadership development for women; holistic approaches; adjunctive programming; hormonal mapping; mothers and children treated together; smoking cessation; poverty reduction and supported housing.

Everything we know about treating women applies to the treatment of young women as well. We know that we need to keep our young people in their home communities when we provide treatment to them. It seems that the very families who can least afford the expenses that go along with long-distance phone calls and traveling out of town to visit their children who are in treatment in places like North Bay are the families who are impacted by this. How can a service provider in a community hundreds of miles away, with shrinking resources, be expected to connect those young people back to the community from which they originated? We want to keep our children in this community and treat them here.

As service providers, we have, or could develop, the capacity to realize best practices in treatment, including being able to bring women and their children to treatment together and being able to run some dedicated cycles of treatment for youth that keep them in our home community. It's not money that stands in our way to do this; it's the lack of interministerial collaboration. The Ministry of Children and Youth Services came together with the Ministry of Health and Long-Term Care and developed the best practices in women's and youths' treatment collaboratively, and those are the practices that we operate under, yet the ministries stopped there and didn't create a framework or protocols that would allow me, as a provider who receives money from the Ministry of Health and Long-Term Care, to enable the women I treat, particularly women with young children, to come to treatment with those children. This is a model that has tremendous success, and it's evidence-based, yet I can't get there from here because nobody has developed the framework for me to do it. So that's one of the things that I'm here to ask for today on behalf of women and on behalf of young people. I urge the ministries to come together at the political level and create the framework where these best practices, these evidence-based prac-

tices, could be realized within the capacity of the existing sector, because it's a major barrier.

0910

Page 10, one more issue: It's called "Popsicles and Crack Pipes." Despite our involvement in recovery, whether personally, professionally or both, we need to protect freedom and support the values of harm reduction when it comes to drug paraphernalia. We believe that an adult who wants to go into a so-called head shop and make a purchase of merchandise that is being sold legally should have that right. Anyone who patronizes one of these establishments knows exactly what they're getting into.

As an organization that is for women, by women, our commitment to freedom and harm reduction needs to be balanced against the need for supporting those in recovery and, perhaps even more importantly, prevention work for our children. The honourable member from Whitby—Oshawa introduced a private member's bill that will lead this province into developing a drug strategy, and one of the pillars will be prevention as part of that strategy, so I think the timing is really good to take a look at this issue.

This forces us to draw the line on having these items on display at our neighbourhood stores where we go in to buy our bread, milk and a summertime Popsicle treat for our children. This has been a real problem for the clients of our facility who are new in recovery and want to avoid being triggered by the sight of these drug-related items. While they know to stay out of head shops and liquor stores, how do they stay out of variety stores? You know, the little shop on the corner, down the street from our community programs, has crack pipes for sale in a display case where women go to get their bus tickets and buy a Popsicle. When we talk to the store owners, they say, "Everybody's doing it; why should we stop?"

The province made an excellent decision when it put a ban on the display of tobacco in Ontario. Three main factors influenced this decision:

(1) We determined that tobacco has become the antithesis to the health of Ontarians and, as such, should no longer be visibly promoted in our communities.

(2) We didn't want to pique the curiosity of children and endorse tobacco products as a normal and expected part of transitioning to adulthood. We want to prevent early experimentation with this gateway drug. Science shows that these displays are effective at enticing children toward these products. The health promotion minister, Margaret Best, said, "It's time convenience stores stopped selling cigarettes right behind the Twizzlers and hockey cards."

(3) We wanted to support those who are quitting or who have quit using tobacco products by removing the trigger that's caused by viewing these addictive substances.

While the display ban moved the tobacco out of sight, the paraphernalia stayed in plain view—those items that are commonly associated with drug use but remain

legally for sale due to their specious connection to tobacco products.

We implore the government of Ontario to include these products in the display ban for all the same reasons that apply to tobacco. These are even more compelling when these items are associated with illicit substances.

To critics that claim that these items are not the same as tobacco products because they don't contain either the illicit drugs that they're connected to or the tobacco, we say that vibrators and other adult toys don't contain the genitalia of the adults, but they're not on the countertop at Mac's Milk.

We've already made a conscious and concerted decision regarding the message that we want to convey. That involves eliminating tobacco from what is acceptable for our children's futures. While we continue to hope that our children will grow into an adulthood that includes healthy sexuality, we still insist that exposure to sexually related merchandise be restricted to them until they're 18 years old. What is it that we hope for our children in adulthood that has us subject them to normalized, routine, early exposure to drug paraphernalia at every corner convenience store in our neighbourhoods?

Let's work together to shape a public policy and community standard that keeps the Popsicles and crack pipes separate so that our kids don't get confused about what is a normal and expected part of their childhood.

The Chair (Mr. Kevin Daniel Flynn): Deborah, thank you very much. You've left a little bit of time for questions, and that was nice. We've got about six or seven minutes. Gilles, do you have anything to kick off?

Mr. Gilles Bisson: Yes. Some of the ideas are the simplest ones in regard to your suggestion of banning crack pipes, and I think that's something somebody might just pick up on in a private member's bill. It sounds like a good idea.

I want to go to the funding issue in regards to the monies that—you're funded from?

Ms. Deborah Gatenby: We receive money from the Ministry of Health and Long-Term Care through the Erie St. Clair LHIN.

Mr. Gilles Bisson: Do you find that, given the work that you have to do, the amount of funding that you get is sufficient? And if you had to change how we fund, what would you do—not so much how much, but how?

Ms. Deborah Gatenby: Obviously, I don't think the funding formula works, but I think that you're going to hear that ad nauseam: "There's not enough money, there's not enough money." What I'm saying is, it's not money that stands between the realization of some of these best practices. If the ministry told me tomorrow that I could run two dedicated treatment cycles of 35 days, where I could bring in a client group of women and their children, it would reduce my bed occupancy, because now I've got kids in some of the beds that I've got patients in right now. But I wouldn't need new money to do that. New money would be nice, but I wouldn't need new money to do that.

The women who are dying because they don't want to reveal the fact that they're struggling with these pills they're taking, because they don't want the CAS involved with their children or they don't want their partner to bring it up as a custody battle issue down the line—by the time I do get them, their kids are going away to college, and they've been taking this stuff for 15, 20 years. If they could come to treatment with their kids—especially women who have younger children and are on their own—we could treat them earlier. We'd have much better outcomes.

It's the same thing with our young people. I could fill my 14 beds with girls who are 12 to 15, whose parents call me on the phone, sobbing, begging for a treatment option. There's no reason my facility couldn't run a cycle of treatment. I'd like to treat them separately from the older client group—

Mr. Gilles Bisson: But what prevents that from happening?

Ms. Deborah Gatenby: One, we're funded by the Ministry of Health and Long-Term Care, which funds patients over 16, and when they're under 16 or when you're going to house their children conjointly and treat them conjointly, it's the Ministry of Children and Youth Services.

Mr. Gilles Bisson: That's why I was asking specifically about how you're funded, because it's a bit of a common problem. So what would you suggest? How should the funding flow in order to make sure that we deal with people generally, so that we have the ability to move from one to the other? Do you have any suggestions?

Ms. Deborah Gatenby: I think it has to happen at a much higher level. That's what we're frustrated about. We say we could make it happen, but how do we make it happen? We're really stretched thin doing what it is that we do, and we're not, quite frankly, that politically savvy. I would say, strike a working group that includes representation from children and youth services and the Ministry of Health and Long-Term Care to do a review of the best practices in treatment of families and youth and women, and talk to service providers on what stands in the way of you making these a reality, and start to get something in terms of a protocol going.

The Chair (Mr. Kevin Daniel Flynn): Helena?

Ms. Helena Jaczek: I lived in Windsor 25 years ago, and I remember hearing of your agency then, because it has such an unusual name.

Just to follow up a little bit, I was really interested in this issue that you've raised about not being able to care for those aged 12 to 15. Could you describe a little bit more how many beds you have for 16 and over, and what geographic area they come from? And is North Bay really the next closest place for the 12-year-olds to 15-year-olds from Windsor to go for treatment? I'm just not clear on exactly how this works.

Ms. Deborah Gatenby: Most of them actually go to Sister Margaret, which is in North Bay, so it's a tremendous problem.

We have 11 beds that are funded by the Ministry of Health and Long-Term Care—the Erie St. Clair LHIN—and we have three private beds. Being a border town, as well as with a really strong CAW presence—some of them have them within their contracts, so those beds are accessible. Right now, we're booking beds for October, because all of our beds are filled, and we're running a waiting list of about 16 women. If a bed becomes available, we'll put them in. Pregnant women do jump the queue and come in right away. We treat them—16 and over. The 12-year-olds to 15-year-olds—that's the problem. There's that cut-off age.

We serve the province. Because we're an integrated trauma treatment and residential treatment model—we do first-stage trauma treatment—we've really become a provincial destination for women to come to.

The Chair (Mr. Kevin Daniel Flynn): Any other questions? Liz?

Mrs. Liz Sandals: I'm still trying to figure out the 16-year-old bar. Do you know if that's true of all adult health services: that you can only go down to 16? I had always thought that addiction, even youth addiction, was funded by health, unlike mental health, where it's clear that health doesn't fund youth mental health—MCYS. But what you're saying is that that's not really quite true; that Health only funds down to 16-year-olds and MCYS would have to pick up anything under 16 on the addiction front as well.

0920

Ms. Deborah Gatenby: Correct, yes. A lot of treatment centres won't take them until they're over 18, but the mandate does dip down to 16 and over.

Mrs. Liz Sandals: Okay. I come from Guelph, so I can remember a time when Homewood, in Guelph, used to do both adolescent and adult treatment. It seemed that the Ministry of Health at some point stepped in and said, "No, you can't mix these age groups together." Have you—

Ms. Deborah Gatenby: Well, Homewood is a bit of a unique environment—

Mrs. Liz Sandals: I know, it's different—

Ms. Deborah Gatenby: —because it's a hospital, so it is a little bit different. We get long-term care, which is mental health and addictions funding, and Homewood gets some actual capital-H health care funding as well, as a hospital.

Mrs. Liz Sandals: Okay, so because you're a treatment program, you can take down to 16 as opposed to a hospital that can only take down to 18?

Ms. Deborah Gatenby: Well, I think a hospital would be able to take them even younger, but no, they can't—well, that might be why they're 18.

Mrs. Liz Sandals: It's quite weird. Okay. But you're beginning to at least describe to us the weird questions we need to get answers to. Thank you.

The Chair (Mr. Kevin Daniel Flynn): Deborah, thank you very much for coming this morning. Excellent presentation.

BULIMIA ANOREXIA NERVOSA ASSOCIATION

The Chair (Mr. Kevin Daniel Flynn): Our next delegation is the Bulimia Anorexia Nervosa Association. Mary Kaye Lucier is with us today.

Mary Kaye, if you'd like to make yourself comfortable; pour yourself some water if you'd like. Like everybody else, you've got 20 minutes to use any way you like. If you leave some time at the end, that would be great.

Ms. Mary Kaye Lucier: Okay. Thank you for hosting this hearing.

The Bulimia Anorexia Nervosa Association, or easily referred to as BANA, is a registered charity membership association, incorporated in 1985, with approximately 500 active members to date. Active members are consumers of our service, staff, volunteers and community partners. We are one of the original founding members of the Ontario provincial network of eating disorder specialty services, which comprises 32 funded specialized eating disorder services from Thunder Bay to Windsor. BANA is also a member in good standing of the Academy for Eating Disorders, the National Eating Disorder Information Centre, the Ontario Federation of Community Mental Health and Addiction Programs and the World Wide Charter for Action on Eating Disorders committee.

BANA is leading a delegation of eating disorder experts to China as part of the People to People ambassador cultural and professional exchange program, an official committee of the President of the United States. We're bringing greetings from the Ontario Premier's office as well while we're in China, and we'll be meeting with the Canadian ambassador to China, formerly the federal director of the Health Canada agency.

As the primary resource for eating disorder treatment, prevention and research services in the Erie St. Clair LHIN, which services Windsor, Chatham and Sarnia, we're honoured to present this brief to comment on the need for expanded specialized treatment and prevention services for eating disorders in this LHIN. The brief has been prepared in consultation with the Ontario outreach coordinator for eating disorders, Dr. Gail McVey, at the Hospital for Sick Children, and is presented by myself, the executive director of BANA. The specialized treatment, prevention and research programs for eating disorders referred to in this brief are based on best practices as recommended by the provincial network, the Academy for Eating Disorders, and the World Wide Charter for Action on Eating Disorders, which I've included in your handout.

BANA is qualified to speak on the issues of eating disorders, given that we're an active member of the network and that we embody a professional commitment to best practices. We engage in forums and advocacy initiatives related to persons affected by eating disorders and we take positions on important related issues. We are the voice of persons with eating disorders in our region.

It is imperative that this public hearing on mental health and addictions hear accurate information based on scientific data and clinical specialists regarding the status of mental health and addictions.

Eating for emotion regulation reasons has been extensively empirically researched and is now well understood within eating disorder diagnoses. Eating disorders are serious mental illnesses characterized as under- or over-eating, followed by methods of unhealthy weight control such as extreme dieting, purging and obsessive exercising. Eating disorders are diagnosed as anorexia nervosa, bulimia nervosa, binge eating disorder or eating disorder not otherwise specified. Motivations for eating disorders vary, including emotion regulation and poor body image, all of which impair decision-making and emotion regulation, especially during the acute phase of the illness. These deficits leave the person feeling hopeless and alienated in their interpersonal relationships. The death rate for these debilitating conditions is the highest for all the psychiatric conditions and can be as high as 15%. Cause of death is usually attributed to cardiac arrest, organ malfunction and suicide. Persons with eating disorders often complete suicide after many years of unsuccessful attempts to recover. The social and systemic costs of these disorders are tremendous.

According to the Erie St. Clair LHIN report of 2005, suicide and suicide attempts are indicators of mental health. The suicide rate for the Windsor-Essex/Chatham-Kent community is higher than the provincial average. For persons with eating disorders, the suicide rate is not calculated, but it's estimated, from the records kept at BANA over the past 25 years, that of the people who have died from their disorder, suicide can be attributed to 50%. The average age of persons who die from complications due to their eating disorder is 26, after a 10-year struggle.

The Ontario provincial network of eating disorder specialty services was established to coordinate and oversee the assessment and treatment of eating disorders in the province. It was created in 1994. The network established a web of specialty hubs and sub-hubs across the province in recognition that the location of services should not determine availability of services. The network is responsible for planning, coordinating and collaborating with eating disorder specialty services, and it conducts annual training and research opportunities, which assists with advocacy initiatives as well.

Existing services in the Erie St. Clair LHIN: BANA is the lead agency in this LHIN that offers specialized treatment. The programs are offered on a continuum, beginning with a specialized diagnostic assessment, followed by psychoeducation, cognitive behavioural therapy and support services. Support services such as nutrition, family education and follow-up are offered, and they are considered an integral component of the treatment continuum. The specialized diagnostic assessment is standardized and was created by BANA in consultation with the network.

Thorough specialized diagnostic assessment for eating disorders is essential to guide referrals for appropriate treatment. The specialized diagnostic assessment sometimes establishes an eating disorder diagnosis when the patient's personal assessment was to the contrary, and vice versa. In either case, the diagnosis allows for referral to the appropriate treatment.

The specialized diagnostic assessment consists of two components: a standardized structured interview, followed by the administration of eight psychometric tests conducted by specially trained social workers. Following the specialized diagnostic assessment, the social workers present the results to our consulting psychologist and physician at the weekly clinical rounds. An individualized treatment plan is formulated, and the treatment plan is discussed with the consumer. Treatment options include psychoeducation, cognitive behavioural therapy, nutrition therapy and follow-up support. These services are conducted pre/post for each treatment option.

All of the data collected from the specialized diagnostic assessment is stored in a research database for the purposes of creating a snapshot of our consumer base for program evaluation and conducting multi-site outcome research. We've been collecting data on the outcomes of our programs for nine years. There are supportive organizations in Windsor, Chatham and Sarnia that offer adjunct complementary services to the specialized eating disorder service in Windsor.

BANA is the lead provider of preventive strategies for eating disorders which focus on health promotion. These strategies include puppet shows on body-based harassment, self-esteem workshops and developing media savvy. Prevention and early intervention are the best forms of treatment, according to our founder, Dr. Richard Moriarty.

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BANA's research strategy is a three-pronged approach designed to evaluate our own programs, to build capacity for more rigorous scientific research, and to conduct multi-site research within the provincial network. Three of BANA's most recent in-house studies are: comparing the outcomes of group participants diagnosed with an eating disorder for psychoeducation with assertiveness training; program evaluation of that psychoeducational group; and third, looking at attachment in adolescents with eating disorders.

The assertiveness training research project demonstrated equal effectiveness in decreasing eating disorder behaviours as traditional psychoeducation. The program evaluation research indicated that there was a high comorbidity of suicidality and attachment problems for teens with eating disorders. This led to our third study, the attachment study, which indicated that teens with eating disorders had fearful and insecure attachments, suggesting that they were more resistant to treatment.

Gaps in services in the Erie St. Clair LHIN:

According to the Erie St. Clair LHIN report, standardized rates for hospitalization for any mental illness are higher in this area than the provincial rate. The

significant medical complications that accompany eating disorders, namely hair loss, tooth erosion, growth retardation, osteoporosis, gastrointestinal bleeding, bowel paralysis, dehydration, electrolyte abnormalities, hypokalemia, hyponatremia and cardiac arrest, lead to eventual death if left untreated, or become chronic.

Hospital stays for persons with eating disorders are significantly longer and occur more often when compared to all other psychiatric illnesses, according to recent data in the UK. The average length of stay for an adolescent in the UK was 90 days. In the US, about 20% more of all in-patient admissions for any psychiatric illness were for children and adolescents with eating disorders.

Intensive in-patient and residential specialized eating disorder services are non-existent in our LHIN. The nearest in-patient pediatric specialized unit is in London, and for adults it's even further, in the greater Toronto area. It's not surprising that the highest referral pattern for out-of-province and out-of-country for eating disorders is from southern Ontario, the Windsor-to-London corridor.

Due to the lack of adequate in-patient programs across the province, there's a pressure for eating disorder programs to find ways to assist clients who are the most needy in accessing the required service. For Windsor-Essex/Chatham-Kent, a designated underserved area, this has meant increased waiting lists for children and adults diagnosed with eating disorders. Many families travel to the US and jurisdictions outside of our LHIN for specialized treatment.

Best practices require residential services after discharge from hospital, which is non-existent in the province. Community-based residential care is a step down from hospitalization before reintegration back into home life, and has been shown to reduce relapse of the disorders and reduce multiple hospital admissions.

Our recommendations to the public hearing on mental health and addictions for best practices service delivery to persons with eating disorders:

Our first recommendation is to recognize that eating disorders are a serious mental illness. The position paper entitled *Eating Disorders Are Serious Mental Illnesses*, crafted for the Academy for Eating Disorders, states that eating disorders "are biologically based ... mental illnesses that warrant the same level and breadth of health care coverage as categorized in this way (e.g., schizophrenia, bipolar, depression, obsessive-compulsive disorder).... [W]e advocate this position unequivocally based on an emerging science that affirms with a reasonable degree of medical and scientific certainty that eating disorders are significantly heritable; influenced by alterations of brain function; significantly impair cognitive function, judgment and emotional stability; and restrict the life activities of persons afflicted with these illnesses.... [T]he denial or restriction of equitable and sufficient treatment necessary to avert serious health consequences and risk of death is untenable and should be vigorously protested."

Our second recommendation is the best practice that treatment is offered on a continuum and within a multi-disciplinary setting. The Provincial Network of Specialized Eating Disorder Services, the Academy for Eating Disorders, the World Wide Charter for Action for Eating Disorders and BANA all endorse this concept. Treatment that is provided on a continuum, that is voluntary and that includes families shows the most promise—treatment that recognizes personal choice and control over one's life as more effective, but also recognizes that institutionalized care must be part of the continuum. Hospitalization, partial hospitalization, day treatment and residential care are some of the continuum options. Funded residential care for eating disorders is, to date, non-existent in Ontario, but in the for-profit sector it shows promise both in Canada and in the US. Private for-profit programs are largely unaffordable for most Canadians.

A continuum of treatment is shown to be more successful in the long term, but because eating disorders have the highest death rate—around 15%—there need to be resources available in every community to adequately and appropriately handle re-feeding and medical monitoring of patients in the acute state of starvation within the specialized treatment hub.

Dr. deGroot states:

"At mid-life, weight dissatisfaction is also ubiquitous, as it is endorsed by 80% of women and over half of women who are 'normal' weight. Further, women with poor body esteem are more likely to avoid everyday activities...."

"The remainder either have persistent eating disorders or mortality. Women with" anorexia "are reported to have 1.5 to 18 times the standard mortality rate ... In British Columbia, the standardized mortality rate (SMR) was 10.5 among adult women with" anorexia "treated on average seven years previously at a tertiary care centre, with death most commonly due to suicide ... Further, 35% of women with" anorexia "were reported to be on disability at a cost of \$2.5 million to \$101.7 million to British Columbia annually...."

The third recommendation is the best practice that requires standardized treatment that is evidence-based. As mentioned earlier, residential treatment facilities for eating disorders are non-existent in Ontario, but should be considered an alternative to in-patient beds for individuals who would otherwise be placed in hospitals and need a highly structured environment with supervised independence. Residential treatment facilities may provide 24-hour staffing and the capacity to handle more chronic clients and facilitate transition to home life. Residential treatment facilities work to normalize and restore eating patterns. The emphasis would be on reintegrating the individual into the community. The specialized diagnostic assessment would lead to the determination of the need for residential treatment facility, and length of stay would be gauged according to individual consumer need.

The fourth recommendation is the best practice to use standardized specialized diagnostic assessment to ensure an accurate diagnosis. Research indicates that this specialized diagnostic assessment is the first step toward developing a treatment plan, which includes a plan for recovery. Although eating disorders are chronic, persons who suffer from them need hope for the future. The specialized diagnostic assessment tracks the onset and the course of the condition, and thereby provides data on the level of severity. Just as persons undergoing other specialized diagnostic assessments for other medical conditions, people with eating disorders feel validated and hopeful that this condition can be treated if accurately assessed. Analysis of the data collected over the past nine years at BANA has indicated that 9% of the referrals that come into our program do not fit criteria for an eating disorder. In particular, there were a number of seven-year-old children who were referred who displayed eating and food-related problems, but the diagnosis was depression or some other mental illness. The treatment plan included reducing fear and anxiety around eating, and referral to a more appropriate children's mental health centre. In particular, these seven-year-old children were in a state of acute food refusal, and their parents were deathly afraid that they were going to lose their child. They didn't have an eating disorder, but they did have problems with food and eating.

The fifth recommendation is the best practice of formulating an individualized treatment plan based on well-researched treatment options. Although treatment should be standardized, individuals need to be treated as unique individuals with a range of options for recovery.

The sixth recommendation is that prevention is the best form of treatment. Although many persons have recovered in generic mental health programs, the rate of relapse is high, and therefore the conditions become chronic over time. Chronicity is best treated within the framework of prevention or early intervention.

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Dr. deGroot, who is associate professor at the department of psychiatry, University of Calgary, responded to the Kirby report, and she cited two large-scale Canadian studies which found that weight concerns begin at an early age and progress to disordered eating attitudes and behaviour with increasing age. She noted that "nearly a third (29.3%) of girls, most of whom were of normal weight and aged 10-14 endorse attempting to lose weight and 10% were ... dieting or using other extreme weight-loss methods, both of which are risk factors for eating disorders. Over 27% of girls aged 12-18 report disordered eating attitudes and behaviours. Of note, only 4% of girls reporting binge episodes and 6% who endorsed purging had ever been evaluated or treated for the behaviours. Such behaviours are of additional concern as they are often associated with additional health-compromising behaviours, such as smoking, alcohol and drug use, depression and suicide. As well, dietary restraint, binge eating, and diet pill use is often associated with an increased risk of obesity."

The Chair (Mr. Kevin Daniel Flynn): Mary Kaye, if I could just stop you there, you've got about a minute left. You might want to go to your recommendations.

Ms. Mary Kaye Lucier: The recommendations—okay.

The Chair (Mr. Kevin Daniel Flynn): Yes. I think you have some at the end. I just read ahead a little bit, and I think that would be a good way to summarize.

Ms. Mary Kaye Lucier: Okay. Our recommendations:

- policies that address workplace wellness programs that focus on healthy living, because everyone is affected by mental health;

- adequate funding for hubs/sub-hubs of eating disorder specialty treatment on a continuum, across the province, especially in Ontario's urban areas, where there's a higher proportion of children who have eating disorder risk factors;

- public education campaigns that integrate healthy eating and healthy activity messaging with the modifiable risk factors to chronic diseases across all sectors;

- school curricula that address healthy lifestyle choices while accepting cultural diversity;

- strategically inform the media on the latest statistical reports that support best practices for prevention of chronic mental illnesses such as eating disorders;

- specialized diagnostic assessment centres that offer a continuum of treatment in the community;

- increase research funding that investigates the high rates of death and disability secondary to anorexia;

- that the National Eating Disorder Information Centre become a truly national program with national funding;

- address the idea of boys and men in ways that increase empathy but don't provide or reinforce sexist/prejudicial behaviours;

- prevention strategies should focus on health promotion rather than on the illness;

- include body-based harassment in anti-bullying policies; and

- reduce screen time for children and increase unstructured play/activity.

The Chair (Mr. Kevin Daniel Flynn): Wonderful. Thank you very much for coming today. All members have a printed copy of your presentation, so they'll be able to review it at their leisure. Thank you for the time you spent. You've made your point very clearly.

EDDI CHITTARO

The Chair (Mr. Kevin Daniel Flynn): If I could call forward the next presenter, Eddi Chittaro. Mr. Chittaro, am I pronouncing your name right?

Interjection.

The Chair (Mr. Kevin Daniel Flynn): Thank you. Like everybody else, Eddi, you have 20 minutes. You can use that any way you see fit. If you could leave some time at the end for questions, that would be great, but if not, it's entirely up to you.

Mr. Eddi Chittaro: Thank you. Mr. Chairman, committee members and support staff, I appreciate the opportunity to be here. My presentation will be somewhat brief, but you may have some questions. I'm relating personal experiences regarding a family member. If you'll bear with me, I'll try not to be too detailed, but I'd like to give you enough background so you'll understand why I gave a lot of thought to being here. In fact, I called Susan and e-mailed her on two occasions; I was going to back out on making this presentation, and I thought, well, it's worthwhile that I be here, in my opinion.

I'm a retired secondary school counsellor/teacher, with about 40 years in that career. Let me give you the background that I wish to explain, and then really get to the reasons why I'm here.

A family member suffered from paranoid schizophrenia for approximately 40 years and was hospitalized at several psychiatric facilities from 1965 to 2004. She admitted herself voluntarily on two occasions, and involuntarily, by my initiative, on two occasions—and the other times are unknown. She didn't live in the community; she lived elsewhere.

One justice of the peace refused to authorize a psychiatric order for examination, and one month later the order was approved by another justice of the peace. Identical information was provided to both justices of the peace. So I have a little concern about justices of the peace.

Let me briefly give you a little history of her hospitalization. In 1965—in the 1970s, in either Paris or Ottawa; in 1984, locally, 116 days in hospital; in 2000, locally, 87 days in hospital; in 2003, locally, 55 days in hospital; and in 2004, 53 days in hospital.

My purpose initially, the issues I had and recommendations to this committee, had to do with involuntary hospitalization by a psychiatric examination order authorized by a justice of the peace. However, since the publication of the notice that was in the Windsor Star on April 22, I spent time reading the Ontario Mental Health Act. What I discovered was that section 33.1 in Bill 68, introduced in 2000—referred to as Brian's Law, which I'm sure you all know is named after Brian Smith, who was murdered by an individual who had paranoid schizophrenia—refers to the community treatment order, CTO, which contained guidelines similar to what I intended to recommend. Believe it or not, I was five years late. Again, I didn't know that that article was in the Mental Health Act; no one told me.

If my understanding of the CTO is correct, for a person with a severe mental disorder who has been in a psychiatric facility for a period of 30 days or more during that three-year period and his or her condition is stabilized, a community treatment order may be established by a committee—a doctor, nurse, social worker, caregiver etc.—prior to discharge. If the patient does not maintain the community treatment plan—medication, follow-up, doctors' appointments etc.—they may be involuntarily readmitted to a psychiatric facility by a doctor's author-

ity. If this is so, then I, who had power of attorney and was the caregiver, was never informed that there was such a thing as a community treatment order in 2000, in 2003, in 2004.

I believed that to involuntarily admit my family member, it was required to obtain a psychiatric examination order and justice of the peace authorization. Obviously, no one told me of the community treatment order. Why was I not informed? My family member certainly met the criteria for the order. The CTO procedures would have been less stressful, more efficient, less time-consuming and much easier to relate to the medical personnel with whom previous contact had been made, rather than some medical person telling me, "If you don't behave"—referring to my family member—"you're going to end up in the psychiatric facility in St. Thomas"—a threat which wasn't needed.

Were the local medical facilities aware of the community treatment order in 2000, in 2003, in 2004 and ensuing years? How are changes to the Mental Health Act conveyed to hospitals and doctors? What follow-up is there that changes to the Ontario Mental Health Act are implemented? What percentage of serious mental patients are re-hospitalized in Ontario for refusal to take medications and allow support? Is it possible that many street/homeless people would not be there if a community treatment order had been initiated? I'm just speculating; I have no idea.

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Another suggestion or question that I have is, why not have the psychiatric order be authorized by not just a justice of the peace but a medical person? And why does it have to be in a court? Why can't it be in a hospital setting? It's an illness. It's a legal matter, certainly; I'm not trying to split hairs here, but to me, anyway, it seems that we're treating an individual legally rather than mentally or physically—we're treating them legally rather than as having an illness is what I'm trying to say.

Tied to my recommendations and conclusions, I wish to refer to the Ontario Mental Health Act, section 33.9, which has to do with review. It reads:

"33.9(1) The minister shall establish a process to review the following matters:

"1. The reasons that community treatment orders were or were not used during the review period.

"2. The effectiveness of community treatment orders during the review period.

"3. Methods used to evaluate the outcome of any treatment used under community treatment orders."

The first review was to take place three years after the article was introduced in 2003. The subsequent review was to take place five years after the three years, so in 2008. I'm assuming it's been done.

Here are my recommendations, very briefly: I strongly recommend that patients and caregivers of seriously ill mental patients be clearly advised by medical psychiatric personnel throughout the province of the community treatment order. Perhaps it's done elsewhere already; I don't know. I'm only speaking from my experience in

my particular locale. Perhaps a pamphlet, a brochure or a handout on the criteria needed and actions available should be developed. Nothing was given to me, nothing was ever told to me by a doctor, nurse, social worker etc.

Conclusion: Except for not being advised of section 33.1 of the Ontario Mental Health Act, the medical care provided for my family member was never an issue or a problem. However, involuntary admission was a problem for me and my family. If a person meets the criteria set forth in section 33.1 of the Ontario Mental Health Act, then it should be implemented without exception.

I hope my presentation will help current and future family caregivers to be better advised and to cope better with a person with a serious mental illness, which is usually difficult and very, very stressful.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for your presentation. You have left a little bit of time for questions, which is great. Is there anybody from this side with a question? Christine or Sylvia? Christine?

Mrs. Christine Elliott: I'd just like to thank you very much for your presentation, sir. The involuntary hospitalization issue is something that we are struggling with and an issue that we want to take a look at—and community treatment orders, because there are some issues around those as well; they are voluntary as well, so they may not apply in every circumstance. But I'm glad that you told us about the fact that you weren't informed of them. I think that's really important. I believe that there is a whole issue with the homelessness aspect of it that we do want to explore, so your thoughts and your being here today have been very valuable. Thank you very much for being here.

Mr. Eddi Chittaro: Thank you very much. I appreciate that.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Christine. Gilles?

Mr. Gilles Bisson: I didn't catch the beginning: Is it a son or a daughter who was in—

Mr. Eddi Chittaro: Sister.

Mr. Gilles Bisson: And you're the primary caregiver at this point?

Mr. Eddi Chittaro: Correct. By the way, she passed away last December.

Mr. Gilles Bisson: My condolences.

Mr. Eddi Chittaro: Thank you. Like I mentioned earlier, I really wasn't going to do anything about it until I saw this notice. That was the issue I had. I really had a problem going back to the justice of the peace. It's not the easiest thing to do. I don't know if you've had the experience. Your motivation is being questioned, obviously, your knowledge, your experience, and believe me—and by the way, I didn't live with my sister. She lived on her own—never married. She lived in an apartment. I would go there occasionally with my wife and so on, and we'd take her out for lunch or breakfast. I could see things. I mean, you don't necessarily have to be a doctor to see a person not acting normally. For example, had I known in 2004 that the CTO existed, had they done

this for me, I would have had her back in the hospital. Unfortunately, she got sicker and sicker, and I was hoping that I'd have time to get her to emergency like I did one or two other times, but anyway.

Mr. Gilles Bisson: I have two questions. I have a sister who's schizophrenic, and I've had to Form 1 my sister three or four times, where she's been a pretty big danger to herself. She's doing well today, knock on wood. She's living on her own and functioning well.

My question is in two parts. The first part: What I've realized over the years is that, unfortunately, most people don't have families to take care of them. Either their family has abandoned them, or they themselves abandoned the family. The community treatment order helps to a degree, but I take it that you still think where the family is there, the family should have some ability and take the responsibility towards that individual.

Mr. Eddi Chittaro: Definitely. Following up your—excuse me; I interrupted you. Go ahead.

Mr. Gilles Bisson: The second part is what really troubles me now. My mother passed away last year and she was the primary caregiver; now I am. What I'm finding is that the mental health system takes care of my sister's mental health, but they don't deal with her physical health, which in the end adds to her mental health problems. I'm wondering if you had the same experience, where your sister may have had difficulty bathing or shopping or whatever it might be—now there are ACT teams for shopping. Do you find that it's not a whole system, that in fact mental health people take care of the mental health problem and the twain never meet?

Mr. Eddi Chittaro: To follow up, my sister also had a hyperthyroidism condition. She refused to take medication after a while. The hospital did a good job, stabilized her and dismissed her. She had some follow-up with a social worker, then refused to see the social worker: "I don't need that. I'm okay." You've heard that story: "Nothing wrong with me. I'm normal." Consequently, her health deteriorated. I knew it. I saw it. I kind of blame myself in a way. I didn't go back to the justice of the peace. I'm sure—I'm not sure; I'm not going to play God here. Perhaps, had I done it, she could still be alive today. The point is you're right.

Not only did she refuse to take the medication for her mental condition, but she also refused to take the medication for her thyroid condition, and that compounded. She became very, very overweight. She wasn't taking care of herself. She was very argumentative. She was rude to people. When we took her to a restaurant, the waitress would be very kind to her, and she'd make some remark that was offhand—that type of thing.

The other frustrating thing is you feel abandoned. You have a social worker come in and say, "She doesn't want to see me." Now what do I do? The social worker obviously can't force herself—what do you do? You know that the consequence is that the medication will not be taken, and she will revert back to where she was. I recorded the many days she was in the hospital. Not to make fun of it, but she certainly took advantage of our

hospitalization time. That's the only thing. Again, I don't know what hospitals do around the country or around the province, and I don't know why this wasn't done here. I don't know whether they knew and they didn't tell me, or they didn't know because no one told them about the act. There was no follow-up.

That's why I'm asking if people can be helped throughout the province with this issue, and it's a really serious issue. They are ill. I don't think it's a legal—I know there are people who perhaps want to take advantage of someone with illness. I realize that, but I think most people who are family members are concerned about getting the person healthy again, maintaining some kind of normality.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Eddi. If there was any question whether you should have come forward, we're all glad you did.

Mr. Eddi Chittaro: Well, thank you very much. I appreciate the opportunity.

CONSUMER COUNCIL, CANADIAN MENTAL HEALTH ASSOCIATION

The Chair (Mr. Kevin Daniel Flynn): Our next presenters will be from the Consumer Council. We've got two women, I believe, Sherry and Diane, if you would come forward and make yourselves comfortable. Have a seat. There's some water there if you need a glass of water before you begin. Make yourself as comfortable as you want.

Ms. Diane Middleton: Thank you.
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The Chair (Mr. Kevin Daniel Flynn): Welcome, Sherry and Diane. Like all the other presenters, you've got 20 minutes. You can use that any way you see fit. If you can leave some time at the end for some questions and a discussion, that would be great, but it's not necessary; it's entirely up to you. The floor is all yours.

Ms. Diane Middleton: Great. I'm going to start. We've given you kind of an outline of where we're going to go.

The Chair (Mr. Kevin Daniel Flynn): Could you identify yourself for Hansard so we can get it in the official recording?

Ms. Diane Middleton: Sure, that would be great. My name's Diane Middleton. I'm a staff liaison with the Consumer Council, a staff member of the Canadian Mental Health Association, Windsor-Essex County Branch, but I'm also a family member. My oldest brother has schizophrenia.

The information that we've compiled for you is the result of input from the Consumer Council, so those are all consumers of programs in our agency and people who have been involved with the mental health system at large coming together to provide some input regarding some of the areas that you've been focusing on in terms of this committee. I've also included some comments, as part of my work—my title is mental health advocate. I do short-term support with consumers, family members, the

community at large and social services agencies, so I've had many years of working with family members seeking help.

I apologize. Both Sherry and I are dealing with throat—with colds and things.

The first comment that was very resounding in the group was talking about the need for counselling. What's currently available is very short-term and solution-focused. The comments that were made were that consumers felt that they could not bring up a lot of past experiences or deal with traumatic life experiences, that they were talking about staying in the moment and focusing on the future. There were some examples in the group where they had been able to deal with past issues through venues like AA—Alcoholics Anonymous—and Brentwood, which is a recovery program for addictions in Windsor. Council members noted that they felt a sense of release when they were able to deal with these past issues. The suggestion was made that OHIP could fund counselling services. That was a suggestion in the group.

There is currently very limited access to a psychologist for the purpose of counselling. Formerly, there was a psychologist attached to the mental health outpatient clinic at Hôtel-Dieu hospital that was available for counselling. That has been discontinued. I would assume the funding was redirected.

Number two: We spoke briefly about alternative therapies. The council identified the need for access and funding for alternative types of therapy—for example, art, music, massage, acupuncture—to assist in recovery. Art therapy is available through Mental Health Connections. They spoke about being able to expand and have more opportunities. But access to massage, acupuncture, as the family member who was here before—I heard at the end you were talking about how for physical health issues, even things like chiropractic and other medical needs, other types of therapy, are not available to folks who don't have the funding for such a need.

Number three, advocacy for service complaints: Certainly, our agency has a complaint process, but one of the members of the council spoke about actually a service within the community at another agency. But they all resounded in talking about the fact that there was some fear in terms of complaining about any kind of service, that they might lose their services. The comment was, when you're mentally ill, you need someone to help you through the steps in terms of bringing a complaint forward. That could be for any kinds of services dealing with financial appeals, any kind of legal process. Certainly, there are law clinics that assist with this, but often the advocacy or the service complaint process is quite long and tiring, and it's very emotionally draining for the person dealing with it, so they spoke about needing someone to help them walk through that.

Number four, peer support and after-hours support: Although at Canadian Mental Health, we do offer some peer support—and I will speak about that briefly later—it's not set up formally as a peer support program or as peer support workers as they do in other areas with ACT

teams. With some mobile crisis teams, they have peer supports available. The council was discussing the benefits of peer supports and how consumers feel more comfortable speaking with a peer about an issue. They also discussed the fact that there are limited after-hours services. Several folks acknowledged that the crisis service that's available out of Hôtel-Dieu hospital, including the mobile crisis service, has been very helpful.

Number five, consumer survivor initiatives programming: The council identified the need for more options for consumers who are further along in their recovery. When the restructuring was done before the LHINs came in—this was several years ago, the mental health restructuring of the different agencies—there was a view to, obviously, not having different agencies overlap or offer the same services.

All the consumer survivor initiatives or programming came under one umbrella or one agency, so what the council members were commenting on is that they felt that they were all being put in one basket, that they only had this one option and if they didn't fit in with the one option, it didn't give them any other venues. They found that the current programming available through Mental Health Connections—they needed more, different programs and something that was more challenging. They all identified that there are excellent programs through the local consumer survivor initiatives, but they noted the need for more.

Number six: It alludes to some of the comments that the family member mentioned in the last presentation, folks with mental health issues needing practical help in terms of homemaking. In Windsor, previously, through the city of Windsor, there was a homemaking program that was accessed through other consumers that was very practical in terms of being able to get housework done, light housework, as well as even yard work for folks who actually owned their own home. Just some practical things in that, when the person was not doing well, they were able to access that, and it was really helpful in terms of just being able to function and work on their recovery. As I've noted here, it used to be available for folks with physical limitations as well as mental health issues.

There is currently, through the VON home help program, some help of this kind, but there is a fee attached. As well, I don't believe it fits the criteria. It does not fit for folks with mental health issues who are physically able to do the work themselves. I'm talking about when a person's symptoms are just to the point where they're not able to do some of those basic household things.

Number seven, integration: The comment was, there is no community life. People need to be incorporated back into community. People need to be helped to get back into other areas of society beyond the mental health system. I think that kind of speaks for itself.

Number eight, and I didn't elaborate—

Ms. Sherry Harder: I'm sorry.

Ms. Diane Middleton: That's all right. Could we just get—

Mr. Gilles Bisson: Are you okay?

Ms. Sherry Harder: Yes. I have bronchitis. I just found out.

The Chair (Mr. Kevin Daniel Flynn): So does my wife, so you're not alone.

Ms. Sherry Harder: Thanks.

Ms. Diane Middleton: Are you all right?

Ms. Sherry Harder: Sorry for the interruption, everybody.

1010

The Chair (Mr. Kevin Daniel Flynn): No problem. I know how it feels.

Take your time—no rush.

Ms. Diane Middleton: I know you guys are on a bit of a clip here.

Okay, number eight—I'll get back to that. This has been an ongoing discussion with the Consumer Council over quite a long period of time about accessing education and employment and some of the difficulty in doing that. Certainly there are programs available to help people access those things. It's fairly limited in terms of the resources. We have two staff at our agency who help people to look for employment. It's very limited at the ODSP office, so as much as those programs are helpful, their comments were that it needs to be expanded.

Number nine, the need for residential treatment for concurrent disorders: Certainly there are places in the province, but there is currently no residential treatment for concurrent disorders in the Windsor-Essex county area. The closest option is in Guelph, Ontario. As well, some residential programs do not accept consumers who are prescribed benzodiazepines, even if the medication is taken as prescribed by their psychiatrist. This presents a barrier for concurrent clients. Later on—I actually forgot to give you this; this will be another handout. This is a community program called the STAGES program, which the Canadian Mental Health Association has been offering for some time now. It's for concurrent consumers. Those are folks with mental health issues and an addiction issue. The description of the group is pretty self-explanatory, but it's been very, very busy. They're having new referrals every week for folks who have gone into addiction treatment and who need some follow-up in the community, but with a specialty regarding mental health as well as addictions. So it's been very successful.

There are two staff attached to this program at our agency. The addiction specialist provides one-on-one support to individuals with concurrent disorders. They meet with individuals who are not yet in the maintenance stage and are trying to stop using substances—and these folks are not eligible to join this community group—refer individuals to appropriate treatment programs if still using substance, and meet with individuals with concurrent disorders who require support and education and do not want to participate in groups. Once again, they facilitate the STAGES group. So that's been something that has been very helpful in terms of the folks who are needing those kinds of services in our area. I'm almost finished.

Number 10, emergency room wait: Consumer Council members identify the difficulty of waiting sometimes up to eight hours in emergency while experiencing a mental health crisis. The quote is, "I needed someone to talk to while I was waiting." Family members have also noted the need for a quiet place in the emergency department for their family member with a mental illness while awaiting service.

Number 11, support to the family unit: As much as through our agency and through the ACT team—certainly, the ACT team has a smaller caseload and sees their folks more often—the family unit is often the 24-hour case manager for folks. The need to provide supports for children of parents living with mental illness, increase collaboration with family supports, inform them of decisions and welcome their input—consumers have identified that. If their family members had more education and supports, it would in turn benefit them in their recovery.

A final comment: The Consumer Council spoke about what it's like to access service and get an answering machine or have to call back or come back to emerg and on and on, and the having to tell people the story repeatedly, and how frustrating that was for them.

I'm going to introduce Sherry. I've gotten to know Sherry over quite a while. She's going to be presenting her personal experience in the mental health and addictions system. She is part of our speaker's bureau at Canadian Mental Health, she has been involved with our staff orientation, and she has also gone out with us in making presentations to social service agencies and the general public. So she has really been doing a lot of work over the last couple of years and educating folks about mental health.

Ms. Sherry Harder: Hello. My name is Sherry. I will be presenting, in chronological order, different things that have happened in my life.

The first one is that I was eight years old when my parents divorced. It was very hard for me. I blamed myself for their divorce.

When I was 11 years old, I had my first drink. My grandparents had crème de menthe at their house, and I thought that stuff was great. I kept drinking it and drinking it, and I felt better all the time. I found that I finally fit into groups—family groups at first, and other groups later—if I drank first.

Also, when I was 11 years old, I had a behavioural problem. I wouldn't listen to my mother. She tried to discipline me in a good fashion, but I just would have nothing to do with it. I rebelled, and my stepfather and I started incest, which didn't help me at all.

When I was 15 years old, I quit school. I had been going to Western Secondary School. It's a school for trades out in Amherstburg. I was only there for about three months, because I was drinking in the back and I was causing trouble in classes all the time so they didn't want me there anymore. They said, "Quit or you're going to get expelled," so I had a great choice there.

I ended up at Maryvale. Now, I know, it's for boys and girls, but when I was going it was just for girls. It was a treatment centre. I was considered disturbed, so I stayed in their cottage for disturbed girls for seven or eight months. Then I ended up going to London Psychiatric Hospital because I was angry and was a threat to myself and to others. While I was still at Maryvale, I got diagnosed with bipolar disorder, and when I went to London Psychiatric Hospital I had been diagnosed with schizophrenia, so I had a tough thing to carry. I used to drink on the grounds outside of Maryvale with my friends—I had some friends who drank with me.

When I was 17 years old, I was discharged from London Psychiatric Hospital to a group home in London. That group home did me a whole lot of good. It helped me get some confidence in myself. It helped me do better in school, because I had gone back to school. It was just, on the whole, a great experience for me. I was there for about two years.

Then I moved back with my father, and there I started drinking heavily again. I didn't remember what I had done or where I went. It was a big mess. I was drinking in bars instead of just on my own, and I tried other drugs when I was 17.

1020

When I was 19, I moved to Windsor with my father and I mixed alcohol with marijuana, which wasn't a very good idea, but I thought it made me feel better. Any time I got depressed or anything, it was like, "Let's have some more marijuana" or "Let's have something to drink. It'll make me feel better." For a long time, that worked for me.

When I was 20, I went to Riverside Secondary School, but I quit Riverside in grade 13 because the work was just too hard and I was too busy drinking. I went to Fanshawe College in London. I stayed there for three months, but they asked me to leave because I was drinking. I was spending more time in their pub than I was in their classes, so that wasn't very good.

At 21 years of age, I started going to psychiatric wards in general hospitals for lack of self-confidence, lack of self-esteem. I took medication but I was still suicidal, and I spent a lot of time trying to get therapy to help me to feel better about myself. But I was still drinking at that time too, so that didn't help.

At 25 years old, I got married and my addiction and mental illness were closer together. My first son, Jason, was born. He's 20 now; he's going to be 21 in September. He goes to St. Clair College, where he takes advertising. He's got one year left, and then he's thinking about taking marketing or something after that.

At 30 years old, my other son, Matthew, was born. I was still drinking in excess, except I did not drink when I was pregnant because I thought that it would not be good for them—the alcohol and the drugs and things—that it wouldn't be good for my pregnancy, so I didn't do it during pregnancy. And I smoked less marijuana at the time.

At 36 years old, I started CMHA treatment. Case management really helped, although not so much with addictions, because at that time they didn't have the STAGES group yet.

At 39 years old, I was fed up with alcohol. My husband said, "Either change or you will not like the changes around here." I started a recovery program and I went to Connaught Clinic for four months. The program was for addictions—alcohol and drugs—and it helped with self-awareness. The program was called concurrent disorders. There I learned a lot about how I responded to things and how I thought about things, and like I said, a lot of self-awareness.

When I was 40 years old, I had admitted to drug addiction. I had taken Tylenol 3s for a toothache I had, and later on the toothache went away but I still kept taking more Tylenol 3s because I felt so good with them. They made me feel like I was better as a person than I was without them. I went to a psychiatric ward and my medications were stabilized.

At 41 years old, I started volunteering at the Canadian Mental Health Association.

At 42 years old, addiction and mental illness were brought together in treatment through STAGES—sobriety through accessing group education and support—at CMHA. That's the group that Diane passed out the flyers about.

In the present, I am six years sober and five years clean, which is without street drugs or drugs that aren't prescribed. I take medication to stabilize my mental illness and I have a family: a husband and two sons.

I was introduced to CMHA through the psychiatric ward at Hôtel-Dieu hospital. Help for my addictions came when my husband said that he was going to make changes at home and I would not like them. The next day, I called a recovery program for alcohol.

In February 2004, I tried to go to the House of Sophrosyne for help with alcoholism. They would not take me because of my mental illness and because I was hearing voices. There is no local in-patient or residential concurrent disorder treatment program. The closest place is Homewood in Guelph, which has a waiting list of four years if you cannot get it paid for through work.

What helps me now in my recovery is partially attendance at recovery meetings. I have a home group and go to three meetings a week. Also, I have literature on alcohol and other drugs. When I was starting to get help, phone calls from peers, other alcoholics, really helped. This still works today. I also have a sponsor, like peer counselling.

In day-to-day life, a constant struggle is finances. The cost of food is rising more quickly than the amount of my disability cheque. Prices are climbing for the same amount of food. If this keeps up, we may have to go to a food bank.

I am happy to give back what was so freely given to me. Help is still needed to expand addictions and mental health services. I will keep putting my foot forward to try

to help the community get what we need. Thank you for listening to my story.

The Chair (Mr. Kevin Daniel Flynn): Sherry, thank you very much. It takes a lot of courage to come forward and say what you did, and we're really pleased you did. Unfortunately, you haven't left any time for questions, which—

Ms. Sherry Harder: Oh, sorry.

The Chair (Mr. Kevin Daniel Flynn): No, hey, that's not your fault. I'm sure there would be interesting questions if we had the time, but unfortunately we have to move on. Thank you very much for doing what you just did. Thanks for the presentation. Diane, thank you for your presentation as well.

CHATHAM-KENT CONSUMER AND FAMILY NETWORK

The Chair (Mr. Kevin Daniel Flynn): Our next presenters this morning are from the Chatham-Kent Consumer and Family Network. Kelly Gottschling and David Hutchinson, if you'd come forward. Good morning. Make yourselves comfortable. There are probably some clean glasses there if you need some water yourselves. Like everybody else, you have 20 minutes. If you could leave some time at the end for some questions, that would be great, but it's entirely up to you. If you'd identify yourselves for Hansard when you speak, that would be great.

Ms. Kelly Gottschling: Certainly. Good morning. My name is Kelly Gottschling. I am the executive director of the Chatham-Kent Consumer and Family Network.

My goal today is to discuss the value of consumer initiatives in Chatham-Kent and in the province of Ontario. What is a consumer initiative? For those of you who do not know, a consumer survivor organization is run by, and often for, persons who live with a mental illness. They are unique in that their strength comes from utilizing the skills of persons who have shared experience within the mental health system. Although medical interventions are often necessary and valued by persons living with a mental illness, there is so much more that adds quality and purpose to our lives.

The people we spend our days with are 16 years of age and older. Ninety-nine per cent of them live well below the poverty level. Their experiences with the mental health system vary. Some of the people we support have been ill for more than 50 years; many of the young folks just in the last few. What they need from the Chatham-Kent Consumer and Family Network is the same: to be respected, safe, encouraged, and to have educational opportunities, personal interactions, the opportunity to volunteer and to be actively and productively engaged in their own communities.

1030

When speaking to the people we support, they say the piece of their lives they miss the most is the opportunity to develop strong bonds with other adults. They wish to become a friend, to nurture that friendship and slowly

leave the isolated world that they were in for many years. The ability to create natural networks of friends, in my mind, is one of the most important things that will assist in long-term recovery for persons living with a mental illness. The thing we recognize most is that after all the service providers close our doors at 4:30 every afternoon, there is nothing left in Chatham-Kent for persons with mental illness. There are crisis staff available, but most of the time people don't need crisis workers; they need someone to have a coffee with, talk on the phone to, to problem-solve, laugh, have fun, or just be heard. The difference between consumer organizations and medical models is that we are proactive and not reactive. When people have a group of their peers that they can count on, as many of us do, they are less likely to become unwell.

Many of the people we support lived for years in long-term mental health facilities. They were released and now, for the most part, live on their own. Most of these folks lost connections with family members. They are often isolated and lonely. When they come to us, most have few or no friends at all. Many have poor life skills because they became ill during the years that they would have learned these skills, or they did not develop them. In the institutions, they did not need them. The skills that they did have at the time were lost years ago. One of our primary goals is to work one-on-one or in small groups to restore these vital skills that people need to live successfully on their own.

Every day, we have new young people enter our building. They are referred by local hospitals and CMHA. These kids are struggling because they are quite ill. Many have lost their friends due to the misunderstanding of their symptoms and, of course, the stigma attached to mental illness. I do not know what it is like to be 16 years old and living with schizophrenia. Being 16 is difficult enough without the symptoms of psychosis. Medical intervention is crucial. Once that has been implemented and working well, then what? Young people need something very special and unique. Because they are already so fragile due to their age and complexity of their symptoms, we must be prepared to offer them what they need specifically. The best way we have found to do so is through education regarding their illnesses, strategies to stay well, a social recreational program that allows them to be young and have fun in a group of their peers who "get them." We participate in formal and informal activities and events in the community together.

The strength of this group comes not from me, as executive director, but from two young people who came to me with the idea that young persons needed a place that was just theirs in which to grow, learn and be accepted. We took a leap of faith, with no funding, and created the Young Minds group for persons aged 16 to 32. Two young men who live with serious mental illness facilitate this group. They are now strong, happy and living well in spite of their symptoms. They go forward and set an example of what it is like to live with a life-altering illness but still have control and hope that their

lives will be productive and happy. They are wonderful role models and wonderful people.

Last year, we provided 5,005 face-to-face visits to 250 persons living with mental illness. We have four staff, two of us full-time and two of us part-time, all chosen very carefully for their education, their life experience and, most importantly, their ability to engage people of all ages and abilities. Our yearly budget is \$177,000.

Our request to you today is to consider the important role that consumer survivor organizations play in the mental health system. We want to be funded in a way that allows our staff to receive health care benefits, which almost none of the consumer survivor initiatives have—and to fund us fairly. We need you to see that our role in the mental health system is valuable, unique and necessary.

I would like, at this time, to introduce Dave Hutchinson. Dave is representing the 250 members of our organization, and he has quite a remarkable story and is a wonderful man. I would like to introduce him on behalf of CKCFN.

Mr. David Hutchinson: Hello. My name is Dave Hutchinson. I represent more than 250 consumers who are members of Chatham-Kent Consumer and Family Network.

A consumer is anyone who uses the mental health system. Examples might be anyone who sees a psychiatrist, psychologist or social worker. I have been a consumer for more than 55 years.

I want to speak of a better approach than waiting until a person is in crisis before coming to his or her aid. The reactive approach just mentioned is necessary but flawed. How can we expect a person unable to cope with personal problems to have those problems solved in a few days in hospital? The likelihood of having to return to hospital again and again is very high.

Now to my main message: I wish to speak of a proactive approach, an attempt to support and prevent return to hospital. Recovery from mental illness takes time.

Consumer initiatives may be new to you. The best way to describe initiatives is to let you look at my life and the difference that CKCFN has made to me. A year and a half ago, I separated from my wife of 40 years and moved to Chatham. I didn't know anyone and was mourning the death of my marriage. As well, I had never been totally responsible for myself and my finances. I was seeking personal autonomy and health. My well-being is greatly improved, physically, mentally and socially, as a direct result of being a member at CKCFN. In what ways? My self-esteem and self-confidence have been enhanced because of my friends at CKCFN. They believe in me. Many friendships, a sense of belonging and getting respect by respecting others are invaluable. I'm growing and more fully realizing my potential. With the encouragement of friends, I have returned to the University of Windsor, which is my alma mater, and I'm in my third year of studies for a second degree. A third degree is also in my plans. I go to university not only for

the pleasure of learning, but some of my studies may help me assist my fellow consumers.

I am a social activist and believe that one person can make a difference. This implies that all of us here today can make a difference.

1040

In conclusion, I am not advocating for more psychiatric beds, nor more psychiatrists, but more consumer initiatives in Ontario. Your ideal model is in Chatham.

The Chair (Mr. Kevin Daniel Flynn): Thank you, David, for your presentation, as well as Kelly.

Let's start with Christine or Sylvia?

Ms. Sylvia Jones: David, I wanted to expand on your comments about your circle of friends—peer support—that you discovered when you went through Chatham-Kent. Was that in a formalized way or was that a network that happened just by virtue of you being part of the organization?

Mr. David Hutchinson: I happen to live across the street and I discovered it after a couple of months and began going. More and more, the persons who attended there became my friends.

Ms. Sylvia Jones: So informal?

Mr. David Hutchinson: I would call it informal, yes. We go voluntarily. None of us are compelled to go in any way. We are not patients, we are not clients; we are members.

Ms. Sylvia Jones: And Kelly, are there opportunities that you make available to encourage those informal networks and peer support?

Ms. Kelly Gottschling: Absolutely. We also have at least four programs per day, so we have educational opportunities as well as social, recreational and rehabilitation programs. We also have things like a men's group, a women's group, our Young Minds group. All those are peer-led. We do pay our peer support staff, which is very unique in the province of Ontario. Most persons who are in a peer support model are not paid, they are there to volunteer, which is too bad, because what they have to offer the mental health system is in many ways far more valuable than—they are people sharing their experiences, triumphs, strategies or skills. But yes, it is available formally and informally.

The luxury that we have is that most of the people whom we meet come almost every day, so we get to learn and we get to see what they like and what they dislike, so we know sort of that this guy likes to play the guitar and this young man who just came in likes to play the guitar, so we could help mould those—in fact, many of our instructors are peers, people who just happen to live with symptoms of a mental illness but have fabulous skills and go forward and teach those. Over half of our programs are taught by peers.

Ms. Sylvia Jones: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Time to move on. Gilles?

Mr. Gilles Bisson: Just following up on your presentation and the ones before, you're part of what is necessary in order to deal with the ensemble of what is

necessary to allow people to live in a community. It seems to me, from my perspective and from what I'm hearing, that it's not necessarily true that various agencies sort of complement each other. You do complement each other, but there's no mechanism to make that happen.

My question to you is, in a community, what is needed in order to be able to make sure that consumers—people suffering with mental illness—are able to get the various types of services that are necessary, because it's clear to me that one agency doesn't provide that, and what would you suggest as a mechanism to make that happen?

Ms. Kelly Gottschling: I think the most important thing is communication. Because, of course, we don't have any kind of marketing pot of money to use to get the word out there, we have to work really closely with our community partners. They have to be aware of what we do, so we go out to services, go to their staff meetings, work with psychiatrists, psychologists, social workers, counsellors. We want to make sure that everyone new coming on board to CMHA has a chance to come out to our building and see what we do. We're really passionate about that and we have excellent, excellent, community partners. Most of the referrals that come to us are word-of-mouth.

There is one thing that I do want to say, if I can, and it's that when a person is diagnosed with a mental illness, if indeed they qualify for services, they often go on a waiting list for up to a year or longer, which is—it's the way it is. It's not great. We wish it was different, but they sit. They may have a piece of paper or a doctor telling them that they have a diagnosis, but then what?

We support moms and dads and kids, women who are 45 years old, just diagnosed, women my age who finally have a title, a name to something, and they want to talk to somebody about it. They want to know what their future is going to hold. They want to know how medications are going to impact their life, their marriage—so many things. We offer that with peer support and education. We have a fabulous resource library.

I think it's really important that when people are diagnosed, they have a next step—not waiting on a waiting list for a year. To access us, you simply walk in the door.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Kelly. Thank you both for being here today. Unfortunately, your time is up.

Ms. Kelly Gottschling: Thank you.

HEATHER LINDSEY

The Chair (Mr. Kevin Daniel Flynn): Our next presenter here today is an individual, Heather Lindsey. Heather, make yourself comfortable. I think we're getting you some clean glasses; I see you brought your own water. You've sat through a few of the presentations now, so you know that everybody's getting 20 minutes. Use that as you see fit. If you'd like to leave some time at the end for questions, that would be even better.

Ms. Heather Lindsey: Yes, definitely. I've practised a little bit; hopefully I can keep it to a minimum and have time for questions.

I'm really glad to be here and glad to meet all of you. I think it's a great initiative, to have this committee going across the province and getting input from consumers, how consumers perceive our current system and our past systems, and what we can do to go forward to support consumers.

My story is just a typical story. It's not extraordinary. As I said, my name's Heather Lindsey, and I'm a 48-year-old woman who has been managing episodes of major depression, anxiety and post-traumatic stress disorder for the last 15 years. I have a university degree from Western, and at the pinnacle of my career I managed a \$3-million-a-year provincial capital grants program which assisted private non-profit organizations from across the province to retrofit their existing buildings so that persons with disabilities and seniors could access their community programs and services. So it's interesting, working with the office for disability issues back in the late 1980s and early 1990s, that things have kind of come full circle.

You know, I had it all. I was 33, I loved my job, I had an office at Queen's Park, the power centre of the province, and I was making a difference in people's lives, people's everyday lives. I had a beautiful home in the suburbs and I'd been in a long-term relationship and was planning my wedding when I was diagnosed with my first episode of major depression.

Back then, I was a high-energy person. I worked; I was focused and driven. I was the first one in the office and the last one to leave, and I always met my deadline dates. There were times I even stayed all night. I'm proud to say, again, that I never missed a deadline even while I was suffering through crippling anxiety attacks and couldn't get out of bed for days. I still micromanaged things from home.

What started off as crashing on the weekends, sleeping a lot, isolating, not going out or participating in social activities, over time turned into having major anxiety attacks on the platforms of the GO trains in the morning, especially Monday mornings—standing there, not able to move, with one train after another rolling to downtown Toronto. Then, slowly but surely, it went from Mondays—I couldn't get out of my bed and go to work until Wednesday. And then a whole week would go by. I was out of control; my life was out of control and my depression was in control.

1050

Fortunately, working in the field of disabilities and being around people who managed their disabilities, who were productive, high-functioning people, I did reach out for help. I was one of the fortunate ones: I knew where to go to get help. Not everybody does.

But I don't share this story so that you'll feel sorry for me or say how brave I am to be here today, because there are more horrific stories and more courageous people than me. I share this story to show you that any of us—

you, me, your sister, your daughter, your colleague—can succumb to the debilitating effects of mental illness. In our society of ever-increasing pressures to do more with less, to be all things to all people, to manage our households on less money, there are increasing numbers of people struggling, fighting to keep their heads above water. It has created a demand on our mental health system like no other time, and in the foreseeable future, this will just continue to grow. So I applaud you again for taking on this issue.

I have three key messages. Mental illness is an illness; it's not a character flaw, and people should be given the same level of access to care as any other person needing medical attention in this province. We talk about reducing waiting times in emergency rooms. If you think that's long, try to find a psychiatrist here in Windsor-Essex county.

I'll tell you a funny story—and that's the way I've dealt with most things: I kind of deflect depression and mental illness with humour. It's a scary thing for most people and, heck, it's scary for me, and I have to live with it. So I find humour is a more palatable way to bring it forward.

Here's my funny story. I grew up in Windsor. I moved to Toronto, and when I came back from Toronto to Windsor, I was on long-term disability—and it's definitely more affordable here to have a car and live on your own, plus I have family here. When my well-intentioned general practitioner referred me to a new psychiatrist in town, the only hitch was that I was going to be on a one-year waiting list. You've heard about some of those one-year waiting lists. After two years on this one-year waiting list, I said, "There's got to be a plan B because plan A's not working." He put me on another one-year waiting list, and actually, I got in in another year. So the moral of the story is, or the joke of the story is, it took me three years to see a psychiatrist, who spends 10 minutes every few months reviewing my medications. So that one-year waiting list turned into three.

I don't have anything against psychiatrists, and they're hard-working professionals doing the best they can with the time they have. There are only so many hours in the day, and the need is so great. But I challenge you to show me where else in the medical system this would be acceptable. Would a cancer patient be left to wait three years to receive chemotherapy or radiation therapy? No. We'd be outraged. People would be calling your offices; they would be organizing rallies. There would be media campaigns. They would be camping out in front of the legislative buildings until something was done to rectify the situation.

I call on you: It's time for action. We don't need another study; we need real, measurable action with goals, objectives, timetables, implementation and follow-up. We need a paradigm shift or a systematic change in the way people with mental illness are treated. We must raise mental illness to the same level of status as the rest of the health issues facing us, with funding, account-

ability, and emphasis on creating a system that meets the needs of a broad range of disabilities.

As you've heard, today our system is basically more reactive and deals in crisis. I'm not going to talk so much about that because you've already got that speech, so I'll go to my third point.

The great news is that most mental illnesses are treatable. But we can't just rely on medications to manage symptoms. We need to take a holistic, patient-centred approach to care. We need to give people access to affordable, ongoing care. What does this look like? It takes many forms, shapes and sizes. We don't have to reinvent the wheel or go back to the old paternalistic, medical model. There is a very low percentage that do need ongoing institutional care, and, heck, that's okay, but the majority of us just need access to medications, talk therapy and some counselling for us to recover and maintain our recovery and get back to being productive citizens.

In my 15-year travels with mental illness, I'll give you one of the examples that I found was most instrumental in me getting back to work. There was a clinic in Markham Stouffville that was overseen by a psychiatrist and had different personnel—board-certified clinical psychologists, psychologists who were doing their practicums and getting their clinical hours in. They were specializing in a range of fields, from children and adolescents—I'm just going to take some water; my medication is giving me a dry mouth, and my talking, too. They had different specialties. There were a couple of people who specialized in working with children and adolescents, some people who worked with marriage and couples therapy, some who did cognitive behavioural therapy, others who assisted people with post-traumatic stress disorder.

What was so special to me about this clinic was that it worked on a sliding-scale basis. I did have limited insurance coverage through my employer, but I was one of the lucky ones. We're not here to tackle insurance reform, but should there ever be a conference on that, sign me up—but then you'd have to extend it past 20 minutes. What was really great about these folks is it's like—you've probably heard of co-op condos in downtown Toronto, on the Esplanade, and there are people there of all levels of financial ability, those who can afford the highest rate and those who can afford very little. Everybody puts money in the pool, and I think it makes everyone better, because you're all together in the same community. They use this type of effect with the sliding scale. So those who could afford the full rate paid the full rate, and then so on and so on. Those who could not afford it, who were on social assistance, maybe paid \$5, where the person who could afford it paid \$85—because, as you know, psychologists are not covered under any medical plan. Psychologists and social workers are the folks who do the talk therapy that helps you through issues.

I know there are other programs like CMHA that provide educational types of information, and those are

great, but I think the greatest need is to have access to ongoing, affordable services, because, unfortunately, although it's treatable, there are times, just like leukemia, when you have recurrences of episodes.

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Closing remarks: I think it's imperative that we move forward developing a sustainable mental health system that not only treats the most severe among us—we deserve to be treated with the same dignity and to the same level of care as anyone else struggling with a medical condition. The key is developing access to a patient-centred, affordable mental health system that supports people throughout their lifetime, not just when they're in crisis.

In closing, I'm an eternal optimist, although I'm slightly depressed some of the time, and it brings me hope that committees such as yours are going across the province talking to consumers. It's an important step, and I wish you all every success in this venture. It's an important initiative.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Heather, and thank you for your sense of humour. You've still got a lot of Queen's Park in you. I notice you gave us three key messages.

Ms. Heather Lindsey: That's right. You see how I put them in bold, a little highlighting for the stuff in between. I must admit I still have a little Queen's Park in me.

The Chair (Mr. Kevin Daniel Flynn): I have a question. In the business world, from an operations management point of view, there are two ways of assigning the operation to a business. There's finite loading and there's infinite loading. Infinite loading means you just get it; you go there and you get it, whatever it is. Finite loading, obviously, has got to be scheduled. Why do you think the one side of the health care system, those people with broken legs and bleeding and traffic accidents, they get the infinite loading; they get treated right away, but somehow, you can wait three years to see a psychiatrist? How has that evolved?

Ms. Heather Lindsey: Yes, I think it's overwhelming, the broad spectrum. I'm not sure how familiar you are with the history of the mental health system, but it went from a very paternalistic type of system, where those people weren't talked about. There was mention earlier about the stigma. Unfortunately, the stigma is still present even though we're making inroads. Most people, on the news media, who do they see? They see a person who's in crisis, they had a psychotic break and pushed somebody into the subway system. So it scares the heck out of the general public. It's not a warm and fuzzy issue.

You can't solve it by having a surgeon mend your bone. It's more to do with a combination of things from biomedical—to a certain extent, the medications do help to stabilize, but they only treat a basic symptom. They don't take care of the person, the issues, what got you there. I truly believe that you can't just take medication and fix the problem, the old story about "Oh yeah, take a Prozac, and you'll feel happy." Heck, I took a lot of

Prozac, and I still had days where I still suffered with depression—so that type of thing. I am always of the opinion that in conjunction with the medication and that guidance, you need talk therapy. You can't have one without the other. Sometimes you can have the talk therapy without the medication if you have a mild form of depression. You may only need medication for a short time, but some of us need it for the rest of our lives. But you can't make the recovery inroads without some talk therapy.

Right now, that's unaffordable to the average person. Being on long-term disability, I'm seeing a new counsellor. I'm going to take mental health as a priority for me. I don't have coverage anymore. Fortunately, I was over-insured, but I'm taking a portion out of my income and I'm applying it to see a psychologist, and I've done that for many years because it's important for me. If it was more affordable, then there would be better access for people.

I think it goes in conjunction with what Chatham-Kent and CMHA will tell you. They can provide peer support and that kind of thing, but they don't have the resources to provide the in-depth treatment, talk therapy.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Heather. Thank you very much for coming today. It was appreciated. Thanks for your optimism; I share it.

Ms. Heather Lindsey: A long-winded answer; I should be a politician. What was that question again? So that's the long way to the short question.

Mr. Gilles Bisson: That's like being in question period.

The Chair (Mr. Kevin Daniel Flynn): That's right. Thank you very much for joining us today.

Ms. Heather Lindsey: With a little less fighting or animosity. I'm an all-party kind of person.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today.

WINDSOR-ESSEX COUNTY DRUG STRATEGY IMPLEMENTATION GROUP

The Chair (Mr. Kevin Daniel Flynn): Colleen Mitchell is with the Windsor-Essex County Drug Strategy Implementation Group. She's our next presenter. You too have 20 minutes, Colleen. Use it any way you see fit. If you'd like to leave some time at the end, that would be great.

Ms. Colleen Mitchell: That's my plan. Dear members of provincial Parliament, the Windsor-Essex County Drug Strategy Implementation Group is comprised of 25 citizens and organization representatives committed to reducing the harms of substance misuse in our community. We came together in response to community consultations that began in February 2008 and have resulted in the identification of a series of priorities to address substance misuse. This consultation has involved over 200 people and is ongoing.

We would like to commend the provincial government on its efforts to improve the mental health and addiction

system. We thank you for coming to Windsor-Essex county and for the opportunity to share with you some of our findings from this process.

We recognize that when someone is addicted, it is a disease, an illness, with significant physiological, physical and psychological effects. We have also come to understand that people are seeking out and misusing substances for a variety of underlying causes. We have been talking to people in recovery and also to people who are actively misusing substances, and they tell us that they have experienced significant trauma such as sexual, emotional and physical abuse. They have often experienced family conflict, and in the case of youth, they have left the home early and do not have the level of supports needed to make a smooth transition to adulthood.

Many families experience financial stress that ripples through all dimensions of family life. When asked what would have prevented them from turning to substances, many said "family support," and a group of youth told me, "having a positive relationship with my parents." So although we believe that treatment services will always be necessary, our community is committed to shifting the dynamic from a reliance on treating people once they are already addicted to preventing them from ever seeking out substances in the first place. Furthermore, we understand there are many people who have both mental illness and addiction, who require an integrated approach for the treatment.

The balance of my comments will relate to some of the objectives that were articulated for your committee, specifically the mental health and addiction needs of children and youth. By far, the most consistent feedback was the necessity to have strategies that will impact youth. We know our children's mental health system has been experiencing significant demand compared to other centres, and particularly since economic stress has increased for our community. However, even more concerning is the lack of youth-specific addiction services across Windsor-Essex county. Many of our organizations that provide supports to adults have shifted their age criteria to 16 years in response to this need. However, we would also agree that this is not necessarily the best approach. Our community has identified the need to develop a comprehensive strategy for youth, and we have commitment across sectors, including police, educators, youth providers and addiction providers.

Although we have excellent co-operation taking place, one of the top priorities was to talk with youth and find out their concerns and solutions with respect to using drugs. In order for youth to believe changes can occur, they need to be engaged in the solutions.

A primary component of our strategy is a prevention strategy that goes beyond substance prevention and extends to addressing some of the reasons why youth are using or misusing substances. The greatest challenge to developing a comprehensive strategy is that often funding does not recognize prevention. Some very good prevention programs get started; however, they do not continue. Prevention cannot be accomplished with one-

off approaches; it needs to be ongoing and consistent to have any long-term community impact.

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In addition, to develop a comprehensive strategy it is necessary to have a designated resource person whose purpose is to pull the community together and establish the partnerships necessary to ensure everyone's role is defined. Your recently announced healthy communities fund has the potential to demonstrate how sectors can work together to strengthen youth. We were most pleased to see that mental health and substance abuse were considered factors to be addressed within this approach.

A second component is a mechanism to identify youth who are at risk of seeking out substances. When youth are identified in the community, the community needs an immediate response to have the greatest impact and to shift the potential to move towards greater dependence on substances. We currently do not have a coordinated mechanism to address this issue.

Previously I mentioned that youth who become dependent or addicted require youth-specific treatment services that have been designed according to their needs and not to those of the predominant adult population of our current treatment system in Windsor-Essex county. We currently have one youth-specific substance abuse outpatient service with a significant waiting time and we have no youth-specific substance withdrawal management, day treatment or residential beds. We are estimating a minimum investment of \$15 million to look at some of these needs.

You also asked us to address innovative approaches. There are current, innovative models that exist within the mental health system that, if enhanced with the expertise of addiction counsellors, could encourage an integrated approach. These models include the mobile crisis team and COAST, which is a collaboration between the Windsor Police Service and the crisis centre. The COAST program is currently a pilot, and early results suggest that it should be funded ongoing as an integral mechanism to prevent people from unnecessarily accessing emergency room services.

We also have a mental health court that has been in existence for almost two years. This model has proved beneficial to ensuring that people receive mental health treatment and support rather than enter the justice system. A similar model for people who are addicted is one of the priorities in our drug strategy. This model requires collaboration across sectors, including mental health and addictions and the Ministry of the Attorney General.

Overall, the Windsor-Essex county substance abuse system has a strong framework. However, there are components that require strengthening for it to be most effective and to effect change at earlier stages of substance misuse. These areas include additional resources for concurrent disorder programs—that is, mental health and addictions; community-based withdrawal management services with a central phone line and a system of trained peer support volunteers; enhanced outpatient counselling—our community continues to have the

lowest per capita spending on this type of treatment; enhanced methadone services, including capital dollars for an appropriate facility—we know that we have over 400 individuals currently in our methadone program, but we still have individuals leaving the community to go to places like Hamilton and Sarnia to receive weekly methadone supports; drug treatment courts similar to the mental health courts; enhanced crisis supports; a system of accessible family support; and a system of after-care that is free and accessible in every community. This is particularly important in our county area, where transportation can be a major barrier for individuals and families to access supports. We estimate a minimum investment of \$10 million to establish the above required components of our addiction system.

Another factor that the community agreed on was that people with substance misuse issues are presenting for help at the door of many other organizations while not identifying a substance misuse problem. Research indicates that primary care is often where people, especially those with addiction issues, will access services. Primary care models such as the family health teams and community health centres have great potential to assist in early intervention and health promotion addressing substance issues if the professional team were to include mental health/addiction specialists.

Therefore, it becomes essential that staff in organizations across our community have the tools to identify possible substance misuse issues. Training for professionals in these fields is a solution; however, resources are needed.

Our community also identified that they want to develop brief intervention resources that can be used by the person, families, physicians, and other service providers. We will be working together to achieve this goal.

We estimate a minimum investment of \$100,000 to establish a coordinated training program across our community.

Finally, you asked about mental health and addiction needs of francophone and ethnic groups. Windsor-Essex county is one community in the southwestern Ontario region with some identified cultural and linguistic needs. We have the highest proportion of mother tongue/French-only population among counties in the southwestern Ontario region. We also have the fifth-highest proportion of foreign-born population across Canada, and the fourth-highest in Ontario, based on the last census. The greatest barrier to accessing services and appropriate treatment is language/English proficiency. We encourage a similar approach as the United States, where provision of interpretation within the health system is required and funded through legislation. Interpretation support is particularly important for mental health and addiction treatment, as much of the assessment and treatment processes rely on verbal communication between the professional and the person. As well, when addressing the sensitivity of health issues, most people prefer to speak to the issues in the language they are most comfortable with. This ensures accurate diagnosis and treatment.

Recent immigrants are coming from geographic areas where there has been significant war, torture, trauma and extreme poverty. The mental health needs of recent immigrants are not being addressed because of the lack of designated resources for the intensive supports that are necessary to address post-traumatic stress disorder. This is an example—oops, I didn't turn to the right page here; I know I have another page, but I've lost it somewhere—that addresses the interaction between sectors: between mental health, addictions, and the Ministry of Citizenship and Immigration.

To close, I would just like to say that our community is poised to take action. We are working together, we are trying to bring people across sectors around one table, and we have identified many priorities that we will move on. We recognize that not everything needs resources and that we can make a lot of changes in our system without them, but there are some that will definitely require additional resources.

Thank you very much for your time.

The Chair (Mr. Kevin Daniel Flynn): You have left us a little time for some questions. I think we'll start this time around with Gilles. Was it you?

Mr. Gilles Bisson: Jeff didn't get a chance last time.

The Chair (Mr. Kevin Daniel Flynn): I'm sorry, Jeff, then.

Mr. Jeff Leal: I'll be quick. You talked about providing services or potentially providing services to francophone Canadians. In this area, to provide services for urban aboriginals, are you seeing that as an area where—because the urban aboriginal population is increasing significantly throughout Ontario.

Ms. Colleen Mitchell: Yes. In fact, we have seen that increase in our community as well. Overall, it's maybe not as high a proportion in terms of our total population, but we're seeing the increase. We do have some resources locally that are aboriginal-specific, but in fact I know we only have one mental health and addictions counsellor in that system. So we definitely see the needs, and we see them coming up in some of the other organizations, but, again, we don't always have the skills or the knowledge to be treating within the aboriginal health model.

The Chair (Mr. Kevin Daniel Flynn): Maria?

Mrs. Maria Van Bommel: In your presentation, you talk about how there's a shift from providing services to adults to 16-year-olds. Earlier today we heard from Sherry, whose issues actually started, she said, when her parents divorced and she, by 11, was involved in substance abuse. Are you seeing that shift, even younger than the 16-year-olds—or was that just sort of one isolated event?

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Ms. Colleen Mitchell: No, we are absolutely seeing a shift. I think some of the statistics for the Ontario student drug use survey bear that out for our region of Erie St. Clair, that youth in our community are definitely using substances at younger ages and using at higher rates than other areas. So it's not an anomaly, what she was talking

about, and that's why we're saying we need the youth-specific—you know, we have children's mental health centres in our community. They're great, and I'm sure that they're seeing some substance misuse issues, but essentially their model is more around mental health and not so much the addiction issues. That's why we're saying that we definitely need that level of support if we're going to shift the dynamic.

The Chair (Mr. Kevin Daniel Flynn): Okay, time for a really short question, Liz.

Mrs. Liz Sandals: So am I hearing you properly, then, that if you have a youth under the age of 16, while they might get mental health services, there actually are no addiction services available?

Ms. Colleen Mitchell: We have one youth outpatient assessment service: combined assessment and outpatient, youth-specific. When I say youth-specific addiction, that's meaning that their mandate clearly states substance abuse.

The Chair (Mr. Kevin Daniel Flynn): Thank you. Christine, Sylvia, anything?

Ms. Sylvia Jones: Yes, thank you. You mentioned the COAST program. It's a pilot project. When did it start and who's currently funding that pilot?

Ms. Colleen Mitchell: It started in January 2009, formally. The police officer is funded through the police department resources and the mental health worker is funded through the adult mental health crisis service.

Ms. Sylvia Jones: So the individual agencies came together and saw the need?

Ms. Colleen Mitchell: Yes.

Ms. Sylvia Jones: Thank you.

The Chair (Mr. Kevin Daniel Flynn): You're good?

Thank you very much for coming today. Your presentation was really well-received; it generated some questions. Thanks for taking the time.

Ms. Colleen Mitchell: Thank you very much.

VICTORIA SHEARON

The Chair (Mr. Kevin Daniel Flynn): Just some brief announcements while Victoria Shearon comes forward from the Schizophrenia Society of Ontario. The bus is going to pick up those of us who travelled in on the bus yesterday, at the back of the hotel where we came in, that beautiful door we came in yesterday. We go back to there.

They'd like us to check out of the hotel before lunch; that'll be around 12:30 or 1, whatever. Lunch is going to be in the Windsor Star room, which is downstairs, right at the bottom of the stairs.

Tomorrow morning they want you to check out of the hotel before boarding the bus for the community centre, because we're not returning to the hotel from the community centre. We're going right to Hamilton tomorrow after St. Thomas.

You probably didn't need to hear all that, but we did. Victoria, the floor is all yours. You've got 20 minutes, and you can use that any way you like.

Ms. Victoria Shearon: Okay. I want to start by thanking the members of the Select Committee on Mental Health and Addictions for the opportunity to share my experience with the mental health system and to offer my ideas to improve that system and provide greater hope and help to those directly affected by persistent, serious mental illness, and their families.

My name is Victoria Shearon, and I'm a lifelong resident of Windsor. I would like to share a little of my background as it relates to mental health. I have a family history of schizophrenia. Aunt Harriet, my dad's sister, was diagnosed with schizophrenia in 1947, at the age of 21. She had started nurse's training, but within months her mental health deteriorated rapidly. She was forced to abandon her studies and return home. Her illness eventually progressed to the point where she had to be admitted to the regional mental health centre at St. Thomas. This became her permanent home for over 27 years.

Although my dad was close to Aunt Harriet—we would visit her every summer, but because of family and financial commitments we weren't able to keep in touch more often. My dad did keep in touch with her by mail and the occasional phone call. So the news of the transfer of the long-term-care beds from St. Thomas to Windsor in 2011 will be a huge benefit for Windsor families, because it remains a burden, travelling back and forth to visit loved ones at the regional mental health centre.

My aunt eventually moved to Windsor in 1975 and lived in area rest homes for the remainder of her life. My parents had frequent contact with her; she was always invited over for Sunday dinner and was included at family celebrations and holiday get-togethers.

Personally, I remember her as a very quiet, private person; somewhat difficult to engage in conversation but very pleasant. My dad tells me that she was always very sharp and kept up on current events. We also know she was a hard worker who regularly helped in the kitchen at her rest home and worked at Goodwill Industries here in Windsor for many years. She also loved the freedom of being able to go shopping in downtown Windsor or for long walks whenever she wanted.

Unfortunately, Aunt Harriet's story ended with tragedy. On October 31, 1992, she took her own life. Her body was found floating in the Detroit River after she had been absent from her home for many hours. After struggling with mental illness for over 40 years, we believe she lost all hope. She saw no purpose to her life and no end to her torment. To this day, my dad lives with the guilt that he didn't see signs of her illness, of her intentions. He regrets that he didn't take action when she said that she wanted to walk in front of a car and die. At that time, my dad dissuaded her by reminding her of the trauma that would cause the driver of the car. Being such a kind person, she understood this and never mentioned suicide to him again. But the tragedy remains, and to this day, 10% of people with schizophrenia commit suicide and many, many more attempt it.

I also have a sister with schizophrenia. She was diagnosed with the illness in 1987. We know her husband and two children struggled to deal with her mental deterioration long before that. They had no idea what they were dealing with until her first psychotic break and hospitalization. Because of her illness, her marriage ended and she was alienated from her children for a number of years.

Today, thankfully, although she doesn't have a psychiatrist, she does take her meds faithfully, and hasn't needed hospitalization for over 15 years. She's one of the lucky ones. She has re-established her relationship with her children and has remarried. She and her husband, who also has a mental illness, have their own apartment and are able to manage their lives fairly well, but they always struggle financially and use area food banks regularly. Family members, including myself, help whenever possible with groceries, rides to appointments and sometimes just being a good listener when she's having difficulties.

In 1996, I joined the Schizophrenia Society of Ontario to educate myself about the illness so I'd be better able to help my sister and understand what she's going through. People in the local chapter provided excellent support and a wealth of information, and many of them have become wonderful friends in the process and remain an important part of my support network, as does the Schizophrenia Society.

Unfortunately, I see that it looks like I'm representing the Schizophrenia Society today. Although I am an active member, that's not my direct message. Maybe that misled people. I apologize for that.

The Chair (Mr. Kevin Daniel Flynn): That's okay. As we travel around the province, we expect to hear from your group on a number of occasions.

Ms. Victoria Shearon: I would like to share my experience working at a residential inn for people with persistent, serious mental illness. I have worked at IRIS House since September 2006, and during that time I've learned a tremendous amount about people with the illness and what supports they need to have the best quality of life. To me, one of the most basic needs for someone with persistent, serious mental illness is having a psychiatrist, a specialist. Yet I've learned that while 70% of people in rest homes suffer from mental illness, only 40% have psychiatric care. Compare this to people with heart disease or cancer. Can you imagine if only 40% of those people had a specialist to treat them? How well would they do, and how many would die needlessly from lack of care?

In Windsor-Essex county, for our population, we need 35 psychiatrists. We have only 17, and one of them treats older adults exclusively. Only a few psychiatrists accept new patients, and you can hear from Heather's presentation the difficulty people have with finding a psychiatrist. This huge deficit places many people with persistent, serious mental illness at great risk for homelessness, repeated hospitalizations and even death. Without a doctor who can take care of this most basic need—a

proper diagnosis and appropriate medication—what hope do they have for the best quality of life?

At IRIS, all of our residents have a psychiatrist. This provides them with a doctor who knows them personally, is aware of the history of their illness, knows about their unique symptoms and their unique reactions to medications, who has a trusting relationship with them. I believe a psychiatrist is essential for optimal recovery.

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Yet often this support isn't enough. In May 2008 we had a resident with bipolar disorder who became increasingly manic. He changed from a pleasant, cheerful and polite man to someone who was aggressive, agitated and argued frequently with other residents. Staff often had to intervene to prevent a situation from getting out of hand. Additional meds to manage his symptoms had little effect. As a staff member, I care about all the residents and their well-being. It was very frustrating for me to watch this man's health deteriorate so drastically. All IRIS staff felt that hospitalization was necessary to stabilize him and return his life to normal. But there is the rub: His psychiatrist indicated there were no beds available. This is the second area where the health care system fails to meet the needs of those with persistent serious mental illness: There are not enough beds for psychiatric patients.

At Hôtel-Dieu Grace Hospital, on average eight to 10 people arrive at ER with psychiatric complaints, but only one or two are admitted. In fact, senior staff at IRIS have told me that they find there is less availability of hospital beds for psychiatric problems since 2002, when IRIS first opened, and thus our resident continued to deteriorate until late in June, when he disappeared one afternoon. Although residents do come and go during the day, after several hours of absence and contact with his family, staff decided to file a missing person report. Police were unable to locate him in the downtown area, but he showed up very late that night at his brother's house out in the county. He had walked part way and then when he got tired, he hailed a cab, and his brother, obviously, paid for the cab. In that event, he was brought to ER because it was a crisis situation and was provided with medication to reduce his mania. The next day, he was finally admitted to hospital.

He stayed in the hospital for one month and returned to IRIS House with a great deal of medication changes. He can now enjoy his life at IRIS and his regular outings with his family. I enjoy talking to him each morning and it is such a relief for me to see him doing well. But it took a crisis for him to get well. What if there had been a bed early in May when he started to deteriorate? His life wouldn't have been completely disrupted. His family wouldn't have had to deal with the constant worry and distress during those two months. His hospital stay would most likely have been shortened and his fellow residents wouldn't have had to deal with the constant stressful and upsetting situations that developed, stress that could put their mental health at risk.

Waiting for a crisis is no way to treat an illness. Prevention is far more practical, less disruptive to the person and his family and far less expensive to the health care system. Prompt admission to hospital when deemed necessary by a psychiatrist is another essential need for those with persistent serious mental illness.

Another example is a resident who started to deteriorate in January 2008. He became progressively more argumentative, confrontational and paranoid with residents and staff. He became very unkempt, often refusing to change his soiled shirt or urine-soaked pants. It was very painful for me to watch his decline because he'd been such a pleasant person before and I wasn't able to help, because we repeatedly tried to help. We asked that he be admitted to hospital, and the answer was always the same: "There are no beds right now."

Finally, in mid-November 2008, 10 months after the first signs of his deterioration, the resident confronted another resident who was holding a glass coffee pot. There was a brief struggle and the resident with the coffee pot fell to the ground. The pot shattered, he cut his hand and was sent to ER and received several stitches. Because of that incident, the resident whose mental health had deteriorated was finally admitted to hospital, but again it took a crisis and someone getting hurt this time. Early admission to the hospital would have prevented all of that, and I find it extremely frustrating that people with persistent serious mental illness do not receive timely treatment. I'm angry that this very vulnerable population is not being treated fairly. Mental health is often referred to as the orphan child of the health care system, and I clearly see why that statement has been made.

That resident spent three weeks in hospital. His condition was stabilized and he was discharged in early December. He was somewhat improved but still not himself, and after much encouragement by his family, his psychiatrist and all of IRIS staff, he agreed to start a new medication. This medication has made a huge difference in his outlook on life and his behaviour. He now takes care of himself. He sleeps through the night in his own room instead of wandering all night. He wears clean clothes every day. When he gets up in the morning, his hair is combed and he has brushed his teeth. He is generally calm and pleasant, and it's wonderful to see him well. You may think these are tiny things, but for someone like this man, these are terribly important things, that he is able to live a normal life again.

Again, hospitalization allowed him to be stabilized, and our support at IRIS and his long-term relationship with a psychiatrist enabled him to receive new medication to manage his illness effectively.

I could go on for hours, probably, with more examples, but I know I have limited time, so I want to address a third area where the system fails those with persistent serious mental illness. This is supportive housing. Even if a person had a good psychiatrist to provide effective meds and access to a hospital when needed, what happens if he has no place to live? Many people with

serious mental illness are homeless or in substandard or inappropriate housing. Many people share a room with several people and they share a communal bathroom. One facility in this city has no doors on the toilet stalls. This is considered a minimum standard of care: You have a toilet but you don't need a door. Do you want your loved one to live like this, without the most basic of privacy? I know I don't.

I ask you: Is this the best we can do for people with persistent serious mental illness? I say no. I know there is a better way. If the committee is looking for innovative models that provide real help and real hope to people with persistent serious mental illness, look at IRIS House. IRIS House is a great example of supportive housing that treats residents with respect and responds to their individual needs. Only five rooms are shared by two people, and everyone else has a separate room with a private bath. Our residents have a full program of activities, with two outings planned every week. There is a vocational work program, a fitness program and nutritious, healthy meals and snacks based on Canada's Food Guide. All of our residents have a family doctor they visit regularly. We provide ongoing support and guidance to residents, and we direct them to outside resources depending on their needs. Thus, they have a safe, secure and supportive environment where they can take time to decide what they want and need to move forward with their lives.

Since 2002, IRIS has helped 158 individuals with persistent serious mental illness, 61 current residents and 97 former residents. On average, the 97 transitional residents stayed 14 months. The majority, 81 of them, came from hospital, another rest home or were homeless. After leaving IRIS, all but eight people went to their own apartment, another rest home or to their family home. What a tremendous positive change for these people.

In addition to the excellent quality of life enjoyed by residents at IRIS House, our facility is very cost-effective. I'm told that a day at Regional Mental Health Care in St. Thomas costs \$480, while a day at IRIS House only costs \$47.50—a real deal. A study by IRIS management in 2004-05 found that we had saved the health care system approximately \$1 million in hospital days because we keep people out of hospital. We strive to keep our residents healthy in mind and body. We work with the ACT teams; W-PEP, which is the Wellness Program for Extended Psychosis; the Canadian Mental Health Association; the YMCA; Mental Health Connections, which is a consumer support network; and many other programs, to ensure our residents have all the support they need throughout their stay, whether they are with us for a few months or for the long term.

But we are only one facility. We always have a waiting list of 20 to 30 people and sometimes more. Many wait months and months for a room, and some of them eventually give up and move on to other housing options. But I see the difference in people's lives when they have appropriate supportive housing, and I feel there is an

urgent need for another IRIS House and other facilities like IRIS House.

I would like to conclude with three points regarding access to care for people with persistent serious mental illness. A psychiatrist is an absolute essential for optimal recovery, and we desperately need more psychiatrists in our community. Prompt psychiatric care in hospital, when necessary, is a must. We need to be more proactive, and we need more psychiatric beds. Supportive housing allows people to live with dignity in a safe environment. We need far more supportive housing, such as IRIS House provides.

I want to thank all of you for listening to me, and I would be happy to answer your questions you might have.

The Chair (Mr. Kevin Daniel Flynn): Thank you. You've left time for one brief question, so let's start with Christine or Sylvia.

1140

Mrs. Christine Elliott: Thank you very much, Victoria. IRIS House sounds exactly like the kind of model that we're looking at across the province.

My question was really related to the situation where you have a resident who's deteriorating. Let's just say there was a hospital bed available, but they didn't want to go. How do you deal with that?

Ms. Victoria Shearon: At IRIS House, if the person has deteriorated to the point where they are, perhaps, suicidal or violent or very aggressive, we would call the police and an ambulance. There has never been a time when the person hasn't ultimately agreed to go, because I think, even at their sickest, they realize that they need help. Sometimes they might be against going in the ambulance, but in our experience the ambulance drivers are pretty good at talking to them and explaining their options and how this will help them. They've all had to go, but it's not like they've had to be dragged to the hospital.

So that would be the final solution if things get really out of hand. We're not there to intervene if they're violent, but we do have the resources of the police and the ambulance, who take them to the hospital when they're needed, and that has happened on occasion, yes.

The Chair (Mr. Kevin Daniel Flynn): Victoria, thank you very much for coming today. It really was appreciated.

ANNETTE DUFRESNE

The Chair (Mr. Kevin Daniel Flynn): We have two more delegations for the morning.

The next speaker is Dr. Annette Dufresne. Come forward and make yourself comfortable. There may be some water left. There are some clean glasses, I think.

Doctor, like everybody else, you've got 20 minutes. You can use that any way you see fit, and if you could leave some time at the end, that would be nice. Please introduce yourself for Hansard, as well.

Dr. Annette Dufresne: My name is Dr. Annette Dufresne. I'm a psychologist in the local community. Thank you for your efforts in developing a mental health strategy for the province and for the opportunity to present to you today.

I come before you today as an individual with a passionate concern for the well-being of individuals in our society. I expended considerable time and effort to complete a PhD in clinical psychology so that I could be of assistance to individuals suffering from mental health issues. I have trained and worked in a variety of sectors: community corrections; community mental health, working with adults with serious mental illness; in-patient psychiatry; and part-time private practice psychology.

In my talk today, I would like to focus on three issues: first, the importance of psychotherapy as a treatment for mental disorders; second, the importance of family and community in healing and recovery from mental illness and addictions; and third, the value of psychologists in a publicly funded mental health system.

Psychotherapy includes a broad range of interventions: cognitive behavioural, interpersonal therapy, brief psychodynamic therapy, relapse prevention. It can be conducted using a range of modalities: individual, family, and group. A wealth of research exists that demonstrates the effectiveness of psychotherapy. We can look to clinical practice guidelines for various mental health disorders, where they review the current evidence base for the treatment of disorders, as confirmation of the importance of psychotherapy or psychological treatments.

For example, the clinical guidelines for the treatment of depression developed by the Canadian Network for Mood and Anxiety Treatments, in collaboration with the Canadian Psychiatric Association, recommend cognitive therapy, cognitive behavioural therapy, interpersonal therapy or pharmacotherapy as first-line treatments for depression. Such recommendations are not restricted to the Canadian context; similar recommendations for cognitive behavioural therapy or interpersonal therapy for the treatment of moderate to severe depression are contained in National Institute for Health and Clinical Excellence guidelines from the United Kingdom.

Clinical practice guidelines for the treatment of anxiety disorders by the Canadian Psychiatric Association state, "Psychological treatments play an important role in the management of anxiety disorders." They recommend CBT and pharmacotherapy as first-line treatments for generalized anxiety disorder, panic disorder, social anxiety disorder, obsessive-compulsive disorder and for post-traumatic stress disorder, and exposure-based therapies for specific phobias.

In addition to demonstrated effectiveness for depression and a variety of anxiety disorders, psychotherapy also has demonstrated effectiveness for eating disorders, borderline personality disorder, addictions and as adjunctive treatment in bipolar disorder and schizophrenia. Psychiatric clinical practice guidelines recommend that cognitive behaviour therapy should be offered to individuals with treatment-resistant schizophrenia. In

addition to its effectiveness for mental health disorders, psychotherapy is also beneficial for adjustment difficulties and relationship difficulties and for health conditions such as chronic pain, tension headaches, irritable bowel and obesity.

To take this to a more personal level, I would like to mention some of the difficulties typically faced by individuals who might present for psychotherapy. One of my professional responsibilities is to lead a women's psychotherapy group. If I can present somewhat of a composite picture of a group client, they often grew up in a home where there was some type of abuse, perhaps due to parental addictions, being the victim of sexual abuse or witnessing and being affected by domestic violence. For some, it was horrendous, ongoing abuse. Often, they were not exposed to healthy modelling and teaching around relationships and healthy emotion regulation and emotional expression skills. Often, they had a history of fairly competent functioning in work settings at some point in their lives, but difficulties with mental illness, perhaps depression, bipolar disorder, psychosis or concurrent addiction and mental health issues, disrupted their level of functioning, and they are currently unable to manage work. They are trying to work on their recovery from mental illness, given additional stresses they face with poverty, family dysfunction and social stigma.

One of the strengths of Senator Kirby's report, *Out of the Shadows*, is that it brought the issue of mental illness to a real, human level. It is my hope that you, too, remember that mental illness and addictions affect real people as you face this difficult task of devising a mental health strategy.

In addition to the benefits of psychotherapy for treatment of mental illness, there is also some research showing effectiveness of therapeutic interventions for prevention of the onset of depression. A recent meta-analysis that included 19 studies concluded that preventive interventions can significantly reduce the incidence of depressive disorders. They also concluded that prevention based on interpersonal psychotherapy might be more effective than prevention based on cognitive behavioural therapy. So we can say, therefore, that psychotherapy also holds promise as a preventive approach.

1150

Not only is psychotherapy treatment an effective treatment, but research also shows a demonstrated need. A 2002 mental health and well-being survey of Canadians showed the 12-month prevalence rates for any measured mood disorder, anxiety disorder or substance dependence was 11%. One in five participants met the criteria for a mood or anxiety disorder or substance dependence at some point during their lifetime. In 2003, mental illness accounted for 30% of disability claims. In the 2002 mental health and well-being survey of Canadians, 21% of individuals whose reported symptoms met the criteria for anxiety or mood disorder or substance dependence in the previous 12 months reported that they wanted help for mental health problems but could not get it. Among

those who had unmet needs, the type of care most commonly felt to be required was therapy or counselling, help for relationships, and information on mental illness and treatment.

Research has also shown that, given a choice, many primary care patients with major depression would prefer to be treated with psychotherapy rather than with medication. Despite psychotherapy being well recognized as a recommended form of treatment for mental disorders, the availability of this treatment in the publicly funded mental health system is very limited. Currently, funding from the Ministry of Health and Long-Term Care for psychotherapy treatment is quite limited. Previously, hospitals had outpatient psychiatry/psychology departments that provided psychotherapy treatment, but the majority of these departments have been cut and there are limited services for psychotherapy in community agencies. For individuals with serious mental illness, the ministry funds community agencies for intensive case management and ACT teams, but not psychotherapy. Psychiatrists are funded under OHIP and some are trained to provide psychotherapy, but there's a shortage of psychiatrists in this community and many others, therefore provision of psychotherapy is generally not a regular part of their practice. In the Windsor-Essex county community, ministry-funded services for psychotherapy would include short-term treatment at the mood and anxiety treatment program that is part of Windsor Regional Hospital, and treatment is available for a select population served by a few family health teams and community health clinics that employ social work therapists.

To illustrate the limited availability of this type of service in this community, I heard from a client recently who called the mood and anxiety treatment program that there is currently a one-year wait list to be seen there. The net result of the lack of funding for psychotherapy is that an effective treatment for disorders that are leading causes of disability are not available to a significant number of individuals affected.

Psychotherapy is not only an effective treatment, but it is also cost-effective. A 2006 meta-analysis, where they reviewed 22 studies from a variety of countries that included an economic analysis of CBT, found that CBT is a cost-effective treatment. A large-scale investigation in Australia, looking at the cost-effectiveness of interventions to help guide policy-makers in planning for health services in Australia, concluded that cognitive behaviour therapy by publicly funded psychologists was a cost-effective treatment for generalized anxiety disorder, panic disorder and major depression.

A variety of options exist or have been proposed in other jurisdictions for how psychotherapy could be publicly funded. I'll briefly describe some of these options here.

The first option is a program called volunteers for psychotherapy. This model sets up a system where psychotherapy is provided by mental health professionals who agree to work at a somewhat reduced fee, with fees being covered by public funding, and in exchange for the

psychotherapy that is provided, clients must perform volunteer work in the community for a non-profit, charitable or government organization of their choice.

The second model, currently being conducted in Australia, is better access to psychiatrists, psychologists and general practitioners. Under this model, general practitioners are able to refer persons with an assessed mental health disorder for subsidized psychological therapy.

The third option is psychological treatment centres. This is an option that has been proposed by the Centre for Economic Performance's mental health policy group from the UK. Psychological treatment centres would involve therapists working in teams, with senior therapists making the initial diagnosis and training, supervising and supporting junior therapists. The senior therapists for one geographic area would be based in one building, but the bulk of therapy would be delivered in GP practices, job centres and so on.

Two other countries that cover the provision of psychotherapy are Italy and the Netherlands.

Finally, in Ontario one possibility for funding psychotherapy would be to redistribute OHIP funding for GPs providing psychotherapy and move the funds to psychological treatment centres or mental health professionals in family practice offices.

The second point I would like to focus on is the importance of moving away from solely an individualistic model of services to treat mental health and addictions to one where we recognize the essential role of families and of building a healthy sense of community. Building stronger families, where the roots for building resiliency can be developed, should be an emphasis in prevention efforts. The importance of considering the family system in accessing mental health services should also be considered.

When we look at individuals with serious mental illness, the importance of family and community support is well recognized as an important factor in recovery. We can consider research that has shown there are better outcomes for individuals with schizophrenia in Third World countries, despite the higher amounts spent on health care in developed countries. The presumption is that these results are seen because individuals have better family and community supports in developing countries.

One area of need that I regularly see in my work is for children who have a parent with a mental illness or problems with addiction. We know that when children grow up in a household where one or both parents have a mental illness or addiction, they will be impacted in terms of greater hereditary susceptibility to mental health/addiction issues, but also they'll be impacted because of the effects of mental illness on the parent-child relationship during a period of illness and the general stress mental illness will put on the family. Such children should be prime targets for prevention efforts. Yet often such children receive no outside supports. In extreme cases, children are removed from the home into the custody of a children's aid society and receive no

intervention, other than being provided with a more stable foster family.

The importance of family and healing in community is also vital when we consider services to individuals from diverse communities such as First Nations and new Canadians. We cannot assume that our model of individualistic services, often based primarily on a medical model, will fit for all individuals in all cultures. We might consider the concept of healing circles that are used in First Nations communities and how we might support such initiatives, and also what we might learn from them that may be useful for the treatment of other individuals.

Finally, I'd like to address the importance of the profession of psychology as an integral part of multidisciplinary teams in public mental health systems. Psychologists have extensive post-graduate training in a variety of models of healthy psychological development and functioning, and psychopathology. And yet, I would argue that psychologists are being eradicated from our public health care system. As many general hospitals have faced budget challenges, what are viewed as ancillary services, such as psychology, are generally the first to be cut.

1200

It used to be quite common for hospitals to support psychology departments that often provided psychological treatment in in-patient and outpatient psychiatry. There has been a shift in the mental health system to move from hospital-based services to community-based services, but the inclusion of psychologists has not been a part of this shift. Community agencies have not traditionally employed psychologists and are not being funded to hire any.

There is now a focus on having primary care practitioners play a bigger role in the treatment of mental health disorders. There has been funding for multidisciplinary family health teams, and yet, few have psychologists. There is the view that social workers can do the same work and social workers can be hired at a less expensive rate, and this view is never challenged, even though some masters in social work programs include no specific coursework or supervised practice in psychotherapy. I do not say this to discount the value of the profession of social work, but rather to emphasize the importance of having psychologists be part of a publicly funded mental health system.

To me, the current status in our mental health system shows an underlying bias for mental health care—that it is acceptable to shift to lesser-trained individuals: from psychologists to MSWs to BSWs, to perhaps people with a one- or two-year college diploma. If it was the case of a person who has been diagnosed with cancer, I don't think as a society we would accept that treatment should be provided by the least costly personnel that has some training in the area. Yet in the case of psychotherapy treatment for mental illness, I increasingly see this type of logic being used.

I think I'll stop there and give an opportunity for quick questions.

The Chair (Mr. Kevin Daniel Flynn): Well, that was a great place to stop because you'd used up your entire 20 minutes at that point. That was excellent time management. Unfortunately, we're not going to be able to continue the discussion, but I did want to thank you for your presentation. It was well received, and we all have a copy of it. Thank you, Doctor.

LEONARDO CORTESE

The Chair (Mr. Kevin Daniel Flynn): Our last speaker for the morning is Dr. Cortese. Thank you very much for coming today, Doctor. Have a seat. There's a clean glass down there, if you're going to need any water for your presentation. If not, you've got 20 minutes like everybody else, and you can use that any way you see fit. If you would like to leave some time at the end, that's always appreciated, but not necessary. It's entirely up to you.

Dr. Leonardo Cortese: Thank you very much. First of all, good afternoon. I think we've just hit the 12 o'clock hour, so it is formally the afternoon.

Let me begin by just telling you a little bit about myself. My name's Dr. Leonardo Cortese. I grew up here in Windsor, but spent about 20 years in London, Ontario, and then made my way back to Windsor when the medical school was started about five years ago. I was asked, as well, to come to Windsor to develop a schizophrenia program. I'm sure you probably all had heard of or knew about the tragedy with the Dr. Demers issue a number of years ago. I was asked to come to Windsor and set up a program to help.

I'm an associate professor at the University of Western Ontario. I also have cross-appointments in family medicine, pharmacology and neurology, so that keeps me fairly busy. Here in Windsor, I am chief of psychiatry at Windsor Regional Hospital. I am, as well, the director of the W-PEP program, which essentially is the Wellness Program for Extended Psychosis. Notice that we don't—it's essentially schizophrenia, but we've tried to avoid that terrible name that has so much stigma attached to it. That is essentially who I am and what I'm doing.

I don't have any handouts and I'm not going to read to you because I find that sometimes, just reading from a piece of paper, we lose eye-and-eye contact, and I don't find it very helpful. So I'm going to speak from the heart. I don't think I'll need my 20 minutes, but hopefully I'll have enough time for you to ask any questions that you have.

I wanted to talk about two points this afternoon, one being the issue of schizophrenia and the second being the issue of psychiatry and family practice. Those are the two issues for which I'm hoping I can clarify some of the needs and some of the important issues.

I'll start with schizophrenia. I know that a representative from the Schizophrenia Society was here, and I'm sure they mentioned all the important issues about

schizophrenia, but I'd just like to reiterate a couple of main points. The World Health Organization recently stated that schizophrenia is probably one of the most disastrous illnesses to affect our young adults, more than cancer, more than heart disease, more than suicide, more than depression, more than anything. Essentially, that statement was made because our young adults who are afflicted by schizophrenia have their hopes and dreams, their life, pretty well taken away from them at a time when major decisions are being made.

I'm sure you know that it's very common but not so popular: One in 100 individuals is at risk for developing schizophrenia. However, when you look at the research and the funding for schizophrenia, it's way below what would be expected for an illness that is so high in terms of incidence. In fact, there's more research in tooth decay—and certainly, my respect to tooth decay—than there is in schizophrenia.

I think what has been an issue here in Windsor is that when I was asked to come down and recruited to build a program in schizophrenia, the funding really was not here. In fact, I can get into all sorts of issues about promises that if I came to Windsor, then this would be offered, and we'd be able to do this, that and the other thing. But I think you all know what often happens to those promises. Anyhow, I was determined to get this program together, and we had very, very minimal funding. In fact, most of the funding that has kept our program going has been by private and industry donations. Pretty well, that has been the majority of the funding that we've actually had. One of the hospitals did help us with one nurse, and one of the other hospitals helped us with a physical location, but essentially we are not funded by any government agency at all.

We certainly see the importance of the first episode. I'm not sure if you heard anything about that this morning, but there certainly is a large momentum, actually internationally as well as nationally, that a lot of emphasis should be put on individuals who are at their first break of psychosis, in other words, the typical 16-, 17-, 18- or 19-year-old woman or man who develops their first episode of psychosis. There have been wonderful programs.

I was involved 10 years ago with the London program, helped establish that, then came here to Windsor and helped establish that. The funding is wonderful, and it should be because we are trying to be preventive. All the evidence certainly identifies that if we jump in quickly and treat these young kids—let me call them kids, relatively speaking, because I'm an older guy—if we get in there and intervene at an early age, we can turn around the process of schizophrenia.

Unfortunately those programs are only about two years long, so after they finish up in two years, they come to our program. The research showing how they do within their first two years is fabulous. The data is amazing: They do well in terms of their symptoms, they do well in terms of their quality of life, they do well in terms

of decreasing suicide, and they do well in terms of decreased burden on the family. It is wonderful.

But as soon as you hit that third year, their outcome is a disaster. The outcome is a disaster because the funding for a chronic program—and about 75% of these youngsters in a first episode program will go on to develop a chronic schizophrenia—has really not been there.

1210

We have certain reasons why we've had difficulties in Windsor in terms of establishing good programs. First of all, I'm sure you know we are extremely resource-limited as psychiatrists in this city. There presently are 12 psychiatrists, and if I can compare it to London—same population: 400,000—London has 125. Windsor has 12. We are expected to do all the work, but unfortunately, we're expected to do that work without the proper team around us, and you heard from Dr. Dufresne, who I think did a wonderful presentation.

We, in fact, lack psychologists; we lack social workers; we lack OT workers; we lack everything that the international guidelines on the treatment of schizophrenia state that we should have. We need social workers to help us with family intervention; we need psychologists to do psychotherapy with our patients; we need neuropsychologists to help us assess when individuals are ready to go back to school or go back to independent living or able to be a part of the family and so on and so forth. Without that team around a psychiatrist, it is very limited what he or she can actually do.

Our case managers are nurses, and it has been difficult for some agencies and government committees to see the importance of nurses in the role of case managers. This is essentially because they are able to give medication. They go to the home and they give injections, because individuals with schizophrenia are probably among the most challenged at coming to their appointments. Often, when they don't come to their appointments, the only way that we can assure them having medication is for our nurses to go there and do home visits. In fact, 50% to 75% of individuals with schizophrenia are non-compliant with medication, and when they do not take their medication, tragedies occur.

Unfortunately, we've heard a number of tragic episodes where individuals with schizophrenia have been involved with terrible situations of murder and killings and so on, and unfortunately, that's the only time we hear about schizophrenia in the news.

As well, they represent the highest proportion of the homeless. They have a high rate of HIV. They have a high rate of suicide: 50% of people with schizophrenia will attempt suicide; about 20% will be successful at suicide. Substance abuse becomes a major issue, and often they become victims of crime in cities, so they are hurt, they are stolen from, and so on and so forth. Without treatment, the complications of that become very tragic for them and, obviously, their families.

We have been able in our program, in the W-PEP program, to continue on with, really, almost a negligible budget. Again, as I mentioned, I've done research pro-

jects and have been able to bring some money in, and we've had some wonderful support from the community in terms of private funding. We have, actually, a yearly gala for W-PEP. Some of you may have actually heard about it. We've been able to raise from \$50,000 to \$120,000 per year that goes, essentially, to pay for our staff so that we can keep them going. My worries are that if that funding stops, we have these patients who are essentially, then, in the community without any care, and that certainly presents a terrible, terrible challenge.

The second thing I'd like to talk about is family practice and psychiatry. If you actually look at the research, about 45% of family practice is composed of mental health. So when you go see your family doctor and you look around the waiting room, about half of the individuals there are there because of psychological, mental health issues. Unfortunately, for family doctors—and my full respect to them, and they need to know a lot about a lot of things—mental health is certainly an area where they are challenged.

In fact, when I was at Western, we did a study. We sent a survey to all family doctors in terms of what we could do better for them and so on and so forth, and essentially what they stated was, "We have almost had zero instruction and teachings in medical school." So when you look at the totem pole of priorities, psychiatry and mental health are not among the top. Heart disease, cancer and diabetes—certainly we need to respect them in the fullest, but mental health is not one of them.

So essentially, what is occurring with family doctors in the city—they are desperate to have psychiatric/mental health interventions to help them out. Unfortunately, what is occurring is, if a family doctor is looking to have someone see a psychiatrist, it's a minimum six-month wait. Many psychiatrists are so busy that they have to close their practices—they can't see anyone—which puts the family doctors in a terrible, terrible mess. In fact, I always say that if somebody has to wait for six months when they're depressed or they're suicidal or they're having terrible emotional difficulties, either they will get better on their own or they'll be dead by suicide.

One of the things that has been an initiative is shared care, where there have been family doctors and psychiatrists identified to work together. Unfortunately, that really has not been occurring. There has not been any funding for that. There have not been resources established in the community, what I would call urgent consultation care, where a family doctor could see a psychiatrist within one day, two, three, or certainly within a week, to be able to have some sort of direction. As it is now, that is not occurring, and I think that would be well accepted and well seen by family doctors as an incredible help to their practice and to their patients.

As well, what I believe is that psychiatrists should be able to go to a family doctor's office. It's something that I do sporadically when I have the time, and that is very, very difficult, but often what I try to do is go to the various family doctor clinics in the city and see their patients with mental health difficulties in their office,

which is very rewarding. Family doctors see that as a tremendous help so that they can get the patients who are in grand need seen in their office, and it's certainly most gratifying for the patients.

Many patients, as you can probably identify, do not want to come to see psychiatrists. But when they see them on their home base with their family doctor, it certainly makes a grand difference. I've been so pleasantly surprised at what a difference there is when I go to a clinic with a family doctor and help them to see these patients together. As well, I think it's a nice educational experience for the family doctors.

There is no funding whatsoever for individuals to do that. We had a discussion with some of our psychiatrists so that we would be able to do that on a rotational basis, but many psychiatrists are seeing that there are no resources for that, and therefore, no time as well to do that. But they're willing to put some time aside to help out in that respect.

My sympathies go out tremendously to family doctors and certainly their patients who need to be seen but don't want to be seen at a psychiatrist's office, but who really have important needs.

Those are the two main issues that I want to bring to your attention. I'm sure it's nothing new that you haven't already heard, but I wanted to make sure that you had, again, a chance to hear that situation.

I don't think I've taken that much time—

The Chair (Mr. Kevin Daniel Flynn): No, you did a great job. Thank you, Dr. Cortese. Is there anybody from the government side? Liz?

Mrs. Liz Sandals: Thank you very much for your presentation. This isn't something that you mentioned, but you seem to be in charge of creative solutions. One of the things that I will frequently hear from folks in my constituent office is about families of schizophrenia or other serious mental issues, where the family hasn't burned their bridges totally with the patient, but the family is extraordinarily frustrated because they can see that the patient is off meds, that they're deteriorating, but they can't seem to get a foot in the door with the medical system. If they go to the police, they're told, "Well, they haven't started a knife fight on the street yet. We'll pick them up when they do that." There doesn't seem to be any way to kick-start the relationship. Often, it will be the doc who's saying, "No, no, I don't see that." The family will often pick it up before the doc does. Is there any way we can break this logjam?

1220

Dr. Leonardo Cortese: Yes, and I agree with you 100%. It has certainly been, I think, one of the most frustrating issues for me and, obviously, families as well as patients.

When someone is referred to our program and we sit down and we have our first consultation, we essentially try to educate the client, the patient, that their family is an integral part of their treatment; that all the literature has shown that once you get families involved, patients do better. We actually have them sign a consent sheet when

they come into our program that says they will have the gold standard treatment, everything that we can give them we will give them, we'll bend over backwards to help them and so on and so forth, but they also need to consent that their families will be part of the program. If they say no, then we ask, "Why is that a problem? What is the major issue?" Many of them will say, "I don't want my family to know about private issues." So then we sort of have a compromise: "The private issues about sex or religion or whatever, we'll keep among ourselves, but let's agree to what may be the issues where families can really be helpful." Families see the warning signs before they do and before their family doctor does, and so on and so forth.

While I'm talking about family doctors, on average, somebody who becomes psychotic sees a medical professional five times before they actually are referred on or identified as having a mental health problem. Family doctors, as much as I love them—and I work with them in my cross-appointment with family medicine—do not have that ability to see that. Families do.

As well, we state that as soon as we finish with our first appointment, their families will come in with us, and we will talk about the illness; we'll educate them about things not to do, things to do, and so on and so forth. I think that's extremely helpful.

In fact, I hear from many families that they're often told—this is one thing that I, being a psychiatrist, have stated has been a terrible burden on us and has made us look terrible. Often, historically, we've said, "We only want to see you. We don't want to see the family." The families get a sense of, "My gosh, there must be something I did wrong. Maybe I should have given them a warmer coat in the winter or spoke to them about this or that when they were growing up, and I didn't, so maybe it's my fault." So we did a terrible injustice there.

The other thing that we do to get families connected with us is we have a family workshop on Saturdays. It's only for family members, their loved ones. We do this every few months or so. We get families to come in, and we spend a whole day together. It's not funded, so we fund it ourselves; we put bits and pieces here and there. The family members come in, and we limit it to about 30 so we can have some good interaction. In the first part, the morning, we teach them everything we know about the illness. In the second part of the day, which is the afternoon, we have videotaped scenarios of what not to do as a family and what to do as a family. We show the pre- and the post-. So they begin to talk with each other, they identify with each other. In fact, from there has grown a family support system. We have a family support group that has helped us in fundraising, that has helped us certainly in London when they were going to cut our positions. They actually went to the CEO and threatened to burn down the hospital. I hope that's not recorded.

The Chair (Mr. Kevin Daniel Flynn): That's a pretty good note to close on, though.

Dr. Leonardo Cortese: So we've brought families in, and they've been a part of the program, and clients have seen how important that has been. But you have to certainly maintain some form of agreement in terms of what we won't discuss with family members. Generally, that has worked out really quite well. So that has to occur. Families have to—

Mrs. Liz Sandals: With that prior consent, if you do get a call from the family member saying, "I've noticed this," then you actually have the prior consent to take some action, as opposed to my experience, which is, "Well, I haven't noticed yet, so there's nothing I can do."

Dr. Leonardo Cortese: That's right. We as well inform them that there are things families can do. The most frustrating thing for families is, they see that their loved one is deteriorating, they bring them to the emergency room, and he or she does not want to come into the hospital. They say, "I don't want to come into the hospital." Then the question is, "Do you want to kill yourself or somebody else?" They say, "No." "Well, then you can go home."

The Chair (Mr. Kevin Daniel Flynn): We've got time for one very, very brief question and one brief answer, and then we're through for the day, because we're doing St. Thomas ourselves this afternoon. Christine?

Mrs. Christine Elliott: It was just a quick follow-up: If a family contacts you and says that the family member's deteriorating, would you then call them and ask them to come in and see you?

Dr. Leonardo Cortese: Yes, absolutely, or the case manager would go right to the home.

Mrs. Christine Elliott: What if they say no? How do you deal with that? Is it just through more persuasion that—

Dr. Leonardo Cortese: Yes. We bring them in, the case manager goes over. Essentially, the case manager has formed a trusting bond, and I think that's been the key issue with case managers. If I say, "We need to put you on medication or change your medication," they kind of look at me, saying, "Hmm, I'm not sure," but if the case manager, who essentially becomes their best friend, says, "Do you know what, Johnny? I think maybe this is a good idea. Maybe we need to speak to the family. Maybe you might consider a change in medication," all of a sudden, it's a different response.

Mrs. Christine Elliott: Okay, thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you for being here today and for your wonderful presentation. We're glad you came.

Dr. Leonardo Cortese: You're welcome. Thank you for your time.

The Chair (Mr. Kevin Daniel Flynn): That's it. We're adjourned.

The committee adjourned at 1226.

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MH-11

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ISSN 1918-9613

Legislative Assembly of Ontario

First Session, 39th Parliament

Official Report of Debates (Hansard)

Tuesday 16 June 2009

Select Committee on Mental Health and Addictions

**Mental health and addictions
strategy**

Assemblée législative de l'Ontario

Première session, 39^e législature

Journal des débats (Hansard)

Mardi 16 juin 2009

Comité spécial de la santé mentale et des dépendances

**Stratégie sur la santé mentale et
les dépendances**



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Hansard Reporting and Interpretation Services
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Telephone 416-325-7400; fax 416-325-7430
Published by the Legislative Assembly of Ontario



Service du Journal des débats et d'interprétation
Salle 500, aile ouest, Édifice du Parlement
111, rue Wellesley ouest, Queen's Park
Toronto ON M7A 1A2
Téléphone, 416-325-7400; télécopieur, 416-325-7430
Publié par l'Assemblée législative de l'Ontario

LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

SELECT COMMITTEE ON
MENTAL HEALTH AND ADDICTIONSCOMITÉ SPÉCIAL DE LA SANTÉ
MENTALE ET DES DÉPENDANCES

Tuesday 16 June 2009

Mardi 16 juin 2009

The committee met at 0848 in the St. Thomas Timken Community Centre, St. Thomas.

SUBCOMMITTEE REPORT

The Chair (Mr. Kevin Daniel Flynn): Okay, ladies and gentlemen. For those of you in the audience, the jam-packed seats there, thanks for coming today. We're going to spend the first few minutes just doing some small business items for the committee; then we should be kicking off on time, at 9 o'clock. If I can get someone to read the report. Maria, if you would read the report of the subcommittee decisions.

Mrs. Maria Van Bommel: I would move the adoption of the subcommittee report as follows:

Your subcommittee on committee business met on Wednesday, June 3, 2009, to consider how to proceed with site visits to First Nations communities and recommends the following:

(1) That the committee members, the committee clerk and legislative research participate in site visits of the following communities and institutions. (See Appendix A: Travel Itinerary: Select Committee on Mental Health and Addictions August 23, 2009-August 28, 2009)—which is on the back of the report: Wabaseemoong, Pikangikum or Kitchenuhmaykoosib Inninuwug (Big Trout Lake), Sioux Lookout health services, Kashechewan, Weeneebayko Health Ahtuskaywin.

(2) That legislative research provide background information on services and demographics in the communities that the select committee will visit.

(3) That the Schizophrenia Society of Ontario be invited to appear as an expert witness when the committee resumes public hearings in Toronto in the fall of 2009.

(4) That the committee clerk, in consultation with the Chair, be authorized, prior to the passage of the report of the subcommittee, to commence making any preliminary arrangements necessary to facilitate the committee's proceedings.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Maria.

Susan is taking a look at the three options available: obviously, flying commercially, and getting some competitive prices on two charters as well. It's appearing that in order to accomplish what we want to accomplish,

perhaps the best way and the most economical way is to go by charter.

Are there any comments? Jeff?

Mr. Jeff Leal: The only comment the Ministry of Aboriginal Affairs made to me when we chatted about it—and they're very pleased we're doing a northern tour—maybe, time allowing, to visit a couple of First Nations communities in southern Ontario at some stage of our deliberations. It may be easier if we can look at a future calendar and look at a couple of areas where I think we should visit. That's the only commentary that they had.

The Chair (Mr. Kevin Daniel Flynn): I think what we did when we first set up the budget is we built some flexibility into the budget to allow that type of thing to happen. So I'd suspect we'd be able to accomplish that sometime in the fall, if the committee chose to go that route. It seems like the right route to go.

Mr. Jeff Leal: While First Nations communities in southern Ontario often are located in larger urban areas—they do have greater access, but there are still some barriers, and I think that's what they may want to talk about.

The Chair (Mr. Kevin Daniel Flynn): Absolutely.

Mr. Jeff Leal: Thanks.

The Chair (Mr. Kevin Daniel Flynn): All those in favour? Those opposed? That's carried.

I just want to make note that today the Canadian Hearing Society will be joining us for the afternoon. Last week, they asked for committee approval for two interpreters for ASL for this afternoon at a cost of approximately \$1,000, so we need that covered. Would somebody like to move we approve that?

Interjection.

The Chair (Mr. Kevin Daniel Flynn): Moved by Liz. Okay, all those in favour? Those opposed? That is also carried.

That is the extent of the committee business, so let's go on to our first—I'm sorry. France?

M^{me} France Gélinas: Sorry. I know that I stepped out of the room for a sec, but did we decide if we were going to go to Kitchenuhmaykoosib Inninuwug or Pikangikum?

The Chair (Mr. Kevin Daniel Flynn): Susan is getting some prices on either a commercial flight or a charter. It appears that the charter is going to come in as the best option—to keep the plane for the week. If that happens, either one of those can happen. Potentially even

both, but at least either one—whichever one you think is best, perhaps.

M^{me} France Gélinas: I was just curious to know if we had made a decision, and I think we should, so that Susan can make travel arrangements.

The Chair (Mr. Kevin Daniel Flynn): Do you have any recommendation as to which one?

M^{me} France Gélinas: Either one is fine by me.

The Chair (Mr. Kevin Daniel Flynn): Perhaps we should leave that to the First Nations? Maybe we should get advice from the First Nations or from aboriginal affairs on, if we have to choose between the two, which one we would choose.

Ms. Sylvia Jones: Or what travel arrangements.

The Chair (Mr. Kevin Daniel Flynn): Right. KI is a lot farther than Pikangikum, isn't it?

M^{me} France Gélinas: No, they're both quite far. One is farther west; the other one is a little bit farther north.

The Chair (Mr. Kevin Daniel Flynn): I think the committee is open to go anywhere, basically, just as far as our—if you would leave it in the hands of me and Susan, unless there's any preference?

Mr. Jeff Leal: And MNA will fully—their resources are available to help us organize this at any stage?

The Chair (Mr. Kevin Daniel Flynn): Yes, and we'll make sure we get advice from aboriginal affairs. If anybody else has any comments on it, please let us know. I think what we want to do within the week is see as much as we possibly can, within the five days that we've allowed for the travel. But we don't want to just breeze in and out of places either.

M^{me} France Gélinas: I think, if I remember, Pikangikum has an innovative service model for aboriginal youth and suicide. I'm going by memory, but I think this is where the chiefs' sons—anyway, there were a number of suicides very close to one another, and they put together an innovative way to deal with teen suicide.

The Chair (Mr. Kevin Daniel Flynn): Okay. We'll certainly keep that in mind, then, when we do make the final travel arrangements.

Mrs. Liz Sandals: Which one was that?

M^{me} France Gélinas: Pikangikum. I know there's also a high rate of suicide in Kitchenuhmaykoosib Inninuwug, but I just don't know what kind of services they have.

The Chair (Mr. Kevin Daniel Flynn): Okay. We will make sure that we see as much as we can in the time that we've allowed and we visit what we think are the most appropriate places with the advice from people who know a lot more about these areas than we do—or than I do, certainly.

MENTAL HEALTH AND ADDICTIONS STRATEGY

ONTARIO ART THERAPY ASSOCIATION

The Chair (Mr. Kevin Daniel Flynn): We're close to 9 o'clock, so why don't we ask our first delegation to

come forward. Our first delegation this morning is the Ontario Art Therapy Association, and that's Evelyn Keep.

Ms. Evelyn Keep: Where do you want me to speak?

The Chair (Mr. Kevin Daniel Flynn): You can sit anywhere you like in those four chairs. The mic will be operated for you automatically, so you just relax. You've got 20 minutes for your delegation. You can use that any way you like. If you could leave a little bit of time at the end for any questions the committee might have of you, it would be nice. It's not necessary, but it usually works better that way. Other than that, the floor is all yours.

Ms. Evelyn Keep: Actually, I'm just going to pretty much present the script that you have in front of you, so if you have a better way to use my time, that's fine. There are some very important points in there that I do really want to leave with you.

I'd like to introduce myself. I'm Evelyn Keep and I'm a registered art therapist in Ontario and in the US. I'm a former registered nurse. In my private practice, I have seen psychiatric and mood disorder patients, sexual abuse recovery in adults and suicide prevention, which is also what I taught in the program. For four years, I worked in pediatric oncology and I've lectured and supervised students and internship clients in the program at UWO. I've been on the board of the Ontario Art Therapy Association, I served as the registrar for four years, and for the past five years I have been the ethics chair.

I am also co-chairing a task force comprised of eight psychiatrists and six art therapists. Our mandate is to initiate a clinical master's in psychotherapy and art therapy at the Schulich School of Medicine and Dentistry at the University of Western Ontario. Right now, our target date is in the air because the university is going through restructuring in its department, as is the psychiatric community here in London.

I'm very grateful for this opportunity to present to you on behalf of the Ontario Art Therapy Association, which is a member of the Ontario Coalition of Mental Health Professionals. Art therapists welcome the Legislature's efforts and time and energy to improve mental health services in Ontario. We are particularly enthusiastic that you have taken a comprehensive approach. We believe it is important for this committee to hear from practitioners across the spectrum of mental health care, taking into consideration the valuable contribution of self-regulated groups, such as art therapists who work both adjunctively and in private practice.

The Ontario Art Therapy Association is, as I say, a self-regulated organization. It is a government-chartered, non-profit organization. We are governed by our duly constructed constitution, a code of ethics, and standards of practice and conduct, and we enforce compliance with an ethics standards discipline process. This year we have reviewed, examined and resolved three cases. We have one case in process at this particular time.

0900

Our therapy training is based on a classical, theoretical study of psychology and fine art, and we utilize the

experience of art creation in the service of psychological clinical practice. The students are all taught widely accepted theoretical practice models. Some of us tend to specialize in humanism or behaviour or, you know, whatever along the way.

The practice of art therapy and the value of art therapy is that it goes beyond talk therapy. You don't have to be an artist to study art therapy or to have art therapy. Some people come in and are terrified by the blank piece of paper to begin with, but it doesn't matter what mark they put on there; it is their expression. Sometimes there are painful emotions and memory experiences that cannot be put into words, so we encourage—we are trained to work with them slowly. I have found that even the most resistant client will eventually put something on that paper.

Art therapists don't interpret; we just work with the client. The meaning is whatever the client says it is. However, we do have some techniques for drawing forth the information further, and we, of course, have studied the research on art therapy, so we know what certain symbols mean or a certain direction that it's going. The rate that we move at is established by the client, and it just unravels, layer by layer. If you have the art image out there, removed from just sitting in front of the client and eyeballing and saying, "Tell me your story," then you have this artwork out here. So it's a triangular relationship with the art.

The preparation to become an art therapist is rather rigorous; it's going to be more so in the master's program, but the master's level is the entry level in art therapy around the world and in the US, so that's why it is really imperative that we start that here. We start off with an undergraduate degree, then we have a didactic study of art psychotherapy for two years, and then we have—the total, before you can be registered, is actually 1,750 hours of practicum experience.

We train them across all ages and stages of development, both normal and abnormal. Practicum placements require experience with diverse societal groups and minority populations, including First Nations, new Canadian communities, child and adult illnesses receiving treatment, either physical or mental health care, either in hospital, out of hospital or outpatients. We also give them experience in rehabilitative services such as brain injury, palliative care and end-of-life care, which is where I have specialized, and it's just a wonderful practice, I feel.

In the First Nations in this area, we have art therapists. We have actually had First Nations students in the program who have graduated and registered and are now working back in their own communities. Of course, in the First Nations groups they have a lot of historical expression in their symbols and in their art. It's a very valuable practice there.

One of the examples that I would like to point out to you as to how art therapists serve and have been serving since 1978 is that at the Children's Hospital of Western Ontario, the first pediatric oncology program was begun in 1978, and it has continued without end up until present

day, where it runs five days a week, with three art therapists. They have even recently, in the last two years, expanded into other parts of the hospital, and they treat all children's illnesses within the hospital—dialysis, cystic fibrosis clinic, and the big issue right now seems to be eating disorders.

How's my time? You can interrupt with questions, or you can tell—

The Chair (Mr. Kevin Daniel Flynn): No, you're doing great.

Ms. Evelyn Keep: I'm talking fast.

The Chair (Mr. Kevin Daniel Flynn): No, actually, you're doing really well. You've used about eight minutes. If you could leave maybe eight minutes for questions, that would work out perfectly.

Ms. Evelyn Keep: Well, it's up to you. Do you want to read what I have in the last two paragraphs, or do you want me to keep talking?

The Chair (Mr. Kevin Daniel Flynn): Keep going.

Ms. Evelyn Keep: Okay.

Art therapists practise in a wide range of placements in Ontario. The list is endless as to possibilities. They're just popping up all the time. We are a creative group, and so we say, "Ah, we could work there," we go out, we start a practice, we struggle, and eventually it gets going. Some of these are really interesting. Veterans' affairs, here in London, at the veterans' hospital—they have a huge program, and it has been going for years; 20 that I know of. We work in schools, of course, hospitals, faith communities, and prisons, to mention a few. We had one very brilliant young woman who was working in Kingston Penitentiary for, all in all, about nine years, and then she moved to Toronto.

I have given you a copy of the student placements for the students out of the UWU art therapy program. There are other programs in Ontario and they may have placements other than ours, but most of our placements do develop into full-time employment. Of course, most art therapists maintain some level of fee-based private practice too.

Art therapists do, in many cases, fill the gap between the ministry-funded programs in mental health and the growing demand and the need for greater coverage to cut down on the wait times and that gap, and in exactly this fashion, we have been filling that gap and relieving the OHIP system of that expense. Not all mental health clients really require nor do they seek the medical model of care. I would like to mention in particular the grade school system in Ontario, which, for instance, may have one psychometrist per board. They, of course, manage test instruments. They don't see children. I personally haven't had experience with that, in trying to contact the psychologist connected with the school board—and there just wasn't one. He said, "Do what you're doing. I can't help you."

For the past number of years, the schools in London have been served extremely well by art therapists, who are supervised by registered people. We supervise everything that they do—their contact. We keep in touch with

the placement agencies. We keep in touch with the students' progress, what they're doing and what they're not doing.

We hope the creation of the college of psychotherapy and mental health professionals will soon become a reality. Public protection is the primary concern of the ministry and of psychotherapy. A governing college provides the public with clarification of the standards of its licensed practitioners, as well as an authoritative body to address if there's a complaint.

In summary, I would like to stress the point that mental health consumers would have more accessibility and would be better served if the college includes a broad range of regulated practitioners licensed to practise the controlled act of psychotherapy.

Thank you for your attention.

The Chair (Mr. Kevin Daniel Flynn): You've left exactly eight minutes for questions. That was impressive. Let's start with Sylvia.

Ms. Sylvia Jones: I wanted to get you to expand a bit. You mentioned that there's going to be a change in the education program in the United States and other countries in the world. They're at a master's level, and you're—

0910

Ms. Evelyn Keep: The change is going to take place here.

Ms. Sylvia Jones: Yes.

Ms. Evelyn Keep: Now, Concordia in Quebec does have a master's level.

Ms. Sylvia Jones: Do you have a timeline?

Ms. Evelyn Keep: We had a timeline for 2010, but as I say, the entire psychiatric community here has undergone department change, a head change—their whole construction is different. I think it's to economize—and also the departments at the university. We will rely on space to work our program in; we've already been operating there.

Does that answer your question?

Ms. Sylvia Jones: Yes. Is the program available only at UWO?

Ms. Evelyn Keep: Yes. Our particular program will be available only at UWO. This is ours at the Schulich School of Medicine and Dentistry, in the psychiatry department. It's a stand-alone. But it is not up and running, and I have e-mails all the time from people saying, "Oh, please start it," but, you know, it takes time.

Ms. Sylvia Jones: Thank you.

The Chair (Mr. Kevin Daniel Flynn): France?

M^{me} France Gélinas: Good morning.

Ms. Evelyn Keep: Good morning.

M^{me} France Gélinas: If we look at the continuum of recovery for people who have a mental illness, where do you see art therapy fitting in?

Ms. Evelyn Keep: The continuum of care: Could you define—

M^{me} France Gélinas: No, of recovery; as in primary prevention, health promotion to prevent people from developing mental illness, people in an acute episode of

mental illness, people recovering and people needing support as the acute episode has gone but needing support in the community to keep their disease at bay. I'm calling this the whole spectrum of the recovery, from primary prevention to support. Where do you see your therapy fitting in?

Ms. Evelyn Keep: Art therapy would fit in probably after a diagnosis has been made or a problem has been defined. However, I have done some health teaching with people in depression who are not looking after themselves physically; then I would do dietary or thought reconstruction. Is that what you mean?

Actually, art therapists—I'm trying to think—would be in almost all of that continuum. Many times, psychiatrists come up against a problem—I treated a woman who had chronic and intractable back pain, and she had been treated for it for years. The doctor knew me and said, "Go try some art therapy." Does that answer your question?

M^{me} France Gélinas: Kind of. So basically, you're looking at people who have had an episode, who have got a diagnosis attached to whatever ails them, and you work with them in the acute stage as well as the support stage after.

Ms. Evelyn Keep: Some people self-refer. They know about art therapy in the community and they don't want to initiate talk therapy, so they will approach an art therapist. They don't necessarily have to be diagnosed; we don't always work to a diagnosis.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Evelyn. Jeff?

Mr. Jeff Leal: Evelyn, thanks very much for your presentation. It's fascinating, really. Could I just go back a step? You have an individual who comes in, and you give them the blank piece of paper. Could you just go through that? For want of a better term, what are you looking for? There have been great portraits painted in history, and the portraits clearly demonstrated mental illness on behalf of the painter.

Ms. Evelyn Keep: Yes. Okay. Where do you start?

Mr. Jeff Leal: Could we go to the blank page for a moment?

Ms. Evelyn Keep: Yes.

Mr. Jeff Leal: Just lead me through that.

Ms. Evelyn Keep: The blank page: All right. If you want to know a technique, sometimes they say, "I can't draw; I've never drawn," and I'll say, "What do you think might be on the other side of that piece of paper?" If you know your patient, you pretty well learn everything about them in intake. You learn what their history is and what their problem is in your intake session, and so the piece of paper—you have materials out there, and you say, "Oh, well, just pick up a crayon and scribble. We do scribble drawings; we do line drawings. Scribble all over the page." Sometimes I would say, "Okay, this is my side, that's your side"—you work with the client. I say, "I'll start my side, and you can't come on my side unless you want to. I won't keep you out." So that might show a sort of anger. Those are techniques that are—does

that help? I really wish I could have brought in a case study for you today, but I didn't think the time allowed.

Mr. Jeff Leal: Quickly, the youngest patient who has worked through this, the youngest patient you ever had—a child?

Ms. Evelyn Keep: I worked with pediatric oncology, and I had a little girl who worked with two paintbrushes. I have her picture hanging at home; she painted me a garden. She was two and a half. That was just a distraction when she was in for cancer treatment.

Mr. Jeff Leal: Thanks.

The Chair (Mr. Kevin Daniel Flynn): Thank you. Liz?

Mrs. Liz Sandals: You mentioned that you would do an intake session. What sort of information would you be collecting generally during an intake session? Does some of that intake also sometimes involve information from other medical professions?

Ms. Evelyn Keep: Absolutely, yes. We have forms, forms, forms and more forms that are legally approved. For myself, being a former nurse, I cover everything. If they're taking medications, I want to know that, because many times it's the honeymoon stage, and they'll come in the second week and say, "I just dumped my meds down the toilet." At that point, I say, "I won't see you again until you go back to your doctor, because I'm not in charge of your meds." So the intake covers everything: It covers contacts, doctors, all associations that they are involved with, all their support systems, their history.

Mrs. Liz Sandals: I noticed that—

The Chair (Mr. Kevin Daniel Flynn): Unfortunately, that's the end of our questions and the end of our time. You used it really well. That was interesting. Thank you very much for coming today.

Ms. Evelyn Keep: Thank you.

The Chair (Mr. Kevin Daniel Flynn): For those of you in the audience, I know that old habits die hard, but you don't all have to sit in the back row. You can move up should you have any problems hearing.

ELGIN RESPITE NETWORK

The Chair (Mr. Kevin Daniel Flynn): The next group we're going to hear from is the Elgin Respite Network. We've got Lisa Boyd, Jenifer Deeley and Janice Fisher, if you'd like to come forward and make yourselves at home here. When each of you speak, you need to introduce yourself the first time for Hansard so we know who's saying what. Like all the other groups that are appearing before us on these tours, you've got 20 minutes, and you can use that any way you see fit. If you leave some time for questions, like Evelyn did, that would be great as well. The time is all yours.

Ms. Lisa Boyd: Good morning. My name is Lisa Boyd, and I'm the regional coordinator for respite services in the southwest region of Ontario. I'd like to introduce Janice Fisher, who's the respite coordinator for the Elgin Respite Network—

Ms. Janice Fisher: That's me.

Ms. Lisa Boyd:—and Jenifer Deeley, who's a family and child counsellor with the Oxford-Elgin Children and Youth Centre in Elgin county.

This morning, we're here to talk about respite services as part of the continuum of care for mental health and addictions. Our agenda for this morning will be what is respite, information about the Elgin Respite Network, respite as part of the mental health and addictions strategy, and then questions and comments.

Back in 2005, a group of respite service providers was convened by the Ministry of Children and Youth Services to discuss respite services and form a task group that created a document regarding respite services, which is in front of you, *An Ideal Model for Children and Youth—Respite Services and Supports: From Rest to Resilience*.

0920

As part of our work as a task group, we spent a lot of time talking about what respite is across the southwest region and, ideally, how respite could be delivered to families and children in the southwest. A lot of focus was on the eligibility criteria for respite services. At the time, it was decided that eligibility for respite would be determined by the child with a diagnosis of a mental health or developmental or physical disability or autism. However, in regard to providing support to children and families, we've learned that sometimes it's the caregiver who's incapacitated and needs support so that their child can remain at home.

As a group, we defined respite as a "flexible, periodic, short-term break from caregiving for the purpose of rest and renewal for the family." We also went further, to define respite options that could be made available to families. Within those respite options were in-home respite, which is, for the most part, hourly respite that can be provided in or out of the home with a family member so that the parent or caregiver can have a break. As well, there is out-of-home respite, which is based on overnight respite for 24-hour periods that can also take place in a host setting, or associated home or family care. In addition, there is centre-based respite care, which would be defined as a camp or daycare program. A child care centre setting could also provide hourly supports to families who require a break.

Ms. Janice Fisher: I'm Janice Fisher, the coordinator of the Elgin Respite Network. What is the Elgin Respite Network? We represent approximately a dozen agencies; you'll see some of the logos on our presentation. They are providers of respite; they are counselling agencies or other community support agencies. Some you will recognize, such as VON—we're all familiar with those. Others are the Talbot Teen Centre; they deal with programs for youth in the community. So we represent a broad section of agencies across the county.

What do we do? We administer funds that look at certain types of respite, primarily developmental disability, autism spectrum disorder, children's mental health, which includes those with social, emotional or behavioural needs, or medically fragile. Those are the

areas currently that we look at funding for. How we do that is, we receive applications. We meet on a monthly basis. Applications are received by the committee, normally presented to the committee through a social worker or public health nurse, someone who is working with the family and knows them well. We review those and then will allocate what funds we have available for respite services.

I'm sure I don't need to tell you that we never have enough money for the applications that we receive or what we want to do with them, but we try our best to meet the needs of the families. One of our criteria, though, is that we have to look at the child and the needs of the child: Do they have a functional loss in an area that meets the criteria for the funding? This is assessed through some professional documentation. It can be medical or clinical documentation, various other rating techniques—you'll see some different terminology here: the BCFPI scores, development disability as defined etc. So there has to be some criteria that meet the funds that we deal with in order for us to allocate funding and provide respite to those families.

Who qualifies for respite services? As it says here, "Families and/or caregivers with children or youth who have a functional loss or impairment (social, emotional, behavioural, developmental and physical) that limits ability on a day-to-day basis." These definitions are primarily taken from the document that Lisa referenced, *An Ideal Model*, that was put together by the ministry. What we find frequently in our committee, though, is that we deal with the needs of the child. The child will have a functional loss that creates a need for the parent to have respite, to have a break for rest and renewal. One of the reasons we're here today, and Jenifer is going to talk more about that, is the people that we aren't able to help, and perhaps how respite can play a part in the strategy on mental health and addictions.

Jenifer?

Ms. Jenifer Deeley: The benefits of respite: We put together a little bit of research, and we also pulled some research that comes right from *An Ideal Model*.

One of the things we found was a survey that indicated that 82% of the families who had accessed respite identified it as a critical component of their family support.

A lot of the research that I have here comes out of the States, because for most of it the ideas originated there. As well, what you'll see in some of this research is that a majority of it comes from families with children who have developmental problems. That is again because those were the first sources of respite, so a lot of the research emanates from there.

The research for how it helps with mental health and addictions is newer and it's coming; it hasn't been in place that long, for the most part, here in Ontario. It was in 2006 that we received funds for families caring for a child with a mental health diagnosis, so it's quite new and there is not a lot out there. So bear with us on some of this research.

An evaluation in Iowa found that respite care that was used was statistically significant in decreasing the need for foster care placements. "Not one of the 74 families who accessed..." out of hundreds of families in New Mexico, "entered the child protective services system." So as a benefit to respite, we're not accessing CAS as often.

One source of literature that we found had reasons why people accessed respite services. Now, if you'll see the numbers, they don't add up, because we didn't put all the reasons on the list. Some were just "Other" and some various reasons. But I put the ones that really pertain to what we're talking about today.

The reasons families accessed it were that they felt there was a risk of abuse or neglect if they didn't get a break from their child; some of the parents are struggling with alcohol and drug problems; employment; self care; domestic violence; mental health; and parenting difficulties. This is why the parents are saying they felt they needed the respite.

That same piece of literature also asked the parents what they would have done otherwise with their children, if they didn't receive the respite care services, to take care of some of those things on the list. Some of them would have missed work, school, or job interviews or opportunities. They would have delayed their own care or a family member's care for medical reasons. They would have kept the child in a situation that may have been inappropriate for them. They may have left the child with someone that they didn't feel comfortable with as a caregiver. They may have kept the child in an environment where they may have been exposed to danger. They may have left the child in the care of another child; it didn't specify in the survey the ages of those children, but in the work that we do, we know that the age and maturity level of some of the kids who are caring for others are not always adequate. And some of them may have actually requested a foster placement so that they could deal with what was going on personally.

That same study followed these families up later on regarding the reasons and the problems that they indicated. At one month, 56% of those families were able to resolve the reasons that were necessary for asking for respite, and 39% of them had partially addressed those reasons. At three months, 74% of the families reported that the referral issue was no longer a problem. So basically what we're trying to say is that respite can really help with an awful lot of these problems that the families are struggling with.

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Respite care studies out of New York found some beneficial outcomes. That research showed that it improved the family functioning overall, improved satisfaction with life, enhanced capacity to cope with stress, and improved attitudes. What they were referring to there was improved attitudes toward the children that they were caring for. This comes right out of the document in front of you.

These folks here, Bruns and Burchard, actually did a very comprehensive literature review, and the conclusions they drew were:

"Families who received respite care services were significantly less likely to need out-of-home placement for their child and reported less personal strain of caregiving than did families who did not receive respite care.

"Generally ... respite services is less costly than" other services like "residential care or treatment services."

Again, it is recognized that one of the best ways of supporting children and youth is to protect families' resiliency to care for their own children and youth. What we find in the work that we do is that all families want to look after their own family. It's that sometimes they're struggling to do that because they have a variety of stressors on them.

Current respite resources are only available to support families where the child has a functional loss or diagnosis. In the referrals that we've received as a committee, we recognize that respite resources should be available where the caregivers may have some functional loss associated, possibly, with mental health and addictions.

In the referrals we received, we actually had to say no to a variety of families because the children didn't meet the functional loss criteria. In some of these families where the caregivers are struggling with mental health or addictions, they are actually doing a fantastic job of looking after their children and reducing the impacts of what they have personally going on. We recognize that respite may benefit them, but we haven't been able to say yes because the criteria won't allow us; the child doesn't have a functional loss.

We put together some examples of families that may have been declined when they came to our table. One would be caregivers with mental health diagnoses such as depression, bipolar, or anxiety. The case scenario is: Grandmother is primary caregiver to children—and we're finding more and more grandparents are taking care of the children—and both grandmother and mother have experienced mental health diagnoses over the years. CAS designated the grandmother as the primary guardian. The grandmother's mental health status is approaching deterioration due to the additional stressors of caring for her daughter with a mental health issue and caring for her children, and the natural aging process itself. The grandmother believes that by accessing respite, this would prevent family breakdown, and as professionals we do recognize that as a good possibility.

Another scenario is caregivers with substance abuse problems who are approaching relapse. They are well cared for in terms of support and not using substances currently in their life. The scenario is a father and mother with an infant and a busy toddler, and they struggled with multiple addictions, primarily alcohol, cocaine and OxyContin. There were financial stresses due to job losses, which we don't need to say much about at this time, in the economic climate we're in. That's a pretty big reality. Their natural supports didn't exist, because their past friends were all into drugs and alcohol, so they

made a lifestyle change to distance themselves from those folks. And due to those past lifestyle choices, the families segregated them as well, so they didn't have an awful lot of family support. The caregivers are feeling so stressed that they believe that relapse into their addiction is a possibility, but they believe that if they can get a break from the kids through respite, then they can attend to their own needs around prevention of relapse and job-hunting issues, those sorts of things.

Another scenario that we've seen an awful lot here in Elgin is teen mothers diagnosed with postpartum depression, or just teen moms themselves. A 15-year-old single mother to an infant, with limited natural supports: She left home because of family violence and substance issues going on in her own home of origin. The young mother is attempting to return to school, is diagnosed with postpartum depression, and she feels that a break from her baby would do some good for her—rest and renewal, and be able to carry on.

Just as an aside, I threw in this bit of research. We do know that children from birth to five are believed to be at the greatest risk of neglect and abuse. When you add that to the scenario we just provided, we as professionals truly recognize how respite can really benefit as a cost-effective preventive to problems.

In summary, some of the benefits of respite: It promotes resiliency of caregivers and families; prevents parental mental health crises; prevents parental relapse of addictions; and prevents costly interventions such as residential care, CAS, specialized school interventions, and children's mental health interventions. Respite can prevent children from experiencing emotional problems they wouldn't otherwise have experienced. They can sometimes be traumatized by some of the things that they may witness in a home. They experience attachment and disruption and adjustment issues if they have to be taken out of the home and moved to foster supports. We feel that by enhancing the family's ability, you can prevent some of these problems with the children directly. The research shows that it is cost-effective. As well, it's quite time-effective. A few hours a week can go a very long way.

That's the summary at the end there. A little bit of respite goes a long way for a family, so for us, what we're hoping for is that a part of the strategy will include the fact that we need funds to help families where the caregiver may have some diagnoses or addictions and the child is actually quite insulated, as a preventive to problems coming up.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Janice, and thank you, Jenifer and Lisa. Unfortunately, we don't have any time for questions, but that was a very comprehensive presentation. Thank you very much for coming today.

SELF HELP ALLIANCE

The Chair (Mr. Kevin Daniel Flynn): I'm going to call Allan Strong forward now. Allan is from the Self

Help Alliance. He's the recovery education coordinator. Allan, if you'd like to make yourself comfortable—

Interjection.

The Chair (Mr. Kevin Daniel Flynn): Yes. You sound different at each one of them.

Mr. Allan Strong: Oh, do I?

The Chair (Mr. Kevin Daniel Flynn): That's the really assertive one you're sitting at right now.

Mr. Allan Strong: This is the assertive one? I'll sit at this one then.

The Chair (Mr. Kevin Daniel Flynn): Like everybody else, you've got 20 minutes. Use it any way you see fit. If there is a chance to leave time at the end, that would be a good idea as well.

Mr. Allan Strong: Okay. Thank you, Mr. Chair. Good morning. I'm pleased to have this opportunity to address the committee this morning. I will be referencing the brief that I prepared and that I believe all of you have a copy of. I will be drawing some attention—but I will try to keep my comments concise so we do have an opportunity for questions and conversations.

I am pleased to have the opportunity to come here and address the committee. By way of formal introduction, my name is Allan Strong. I am the recovery education coordinator for the Self Help Alliance. I'll explain more about that as I go through my presentation.

The lens that I view the mental health and addictions system through is primarily a lens that has been gained over 26 years of experience in the system as a care provider, as someone who has dealt with policy issues and who has been quite an active volunteer serving on a variety of boards and committees. I have, in the past, been a member of the Ontario division of the CMHA board of directors, the Ontario Federation of Community Mental Health and Addictions Programs, the Mood Disorders Association of Ontario and a variety of other committees.

I would like to say that this is not the first time I've sat before a committee such as this, looking at mental health and addictions in this province. My tenure in the system has seen four or maybe five significant reviews and examinations of the mental health system, starting with the Graham report, moving on to Putting People First, then Making It Happen, and then a variety of consultations by the Mental Health Commission of Canada. I was actively involved in the implementation task forces, and most recently, I've also been quite active in my community with the emerging discussions around the mental health strategy. So my lens comes as one with professional involvement.

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The other lens that I view the mental health system with, and this is the most intimate and personal lens, is one of a son of a woman who was quite actively engaged in receiving service. My mother was hospitalized a frequent number of times while I was growing up—several of those hospitalizations lasting several weeks. It is through that lens that I also look at the mental health system, realizing that my family life—that of myself and my

two sisters and brother—was coloured and determined by the experience of my mom's involvement with the system.

The final lens is the lens of someone who himself has received service. I've been hospitalized myself four times, and I've had the opportunity to see the mental health system, and to a lesser extent, the addictions systems, first-hand. It is primarily with those three lenses that I wish to make my comments this morning.

I started out by saying that I've been involved in previous reviews and examinations of the mental health system, and as I sit here, I'm somewhat cynically optimistic that the current process of this committee, and also Minister Caplan's initiative to look at the development of a 10-year mental health and addictions strategy, will bring forth some substantive fruit. I say that with full recognition that there has been a great deal of effort, and the desire and the intent of those who have gone before has always been to try to do the best that we can.

However, as I think about it, we often have focused on the how and the what we do, meaning services and programs. We are constantly looking at how we can either re-fund, develop more programs and more services or reconfigure the ones that currently exist to provide better care. Without sounding unduly harsh, my experience has been that it has been somewhat like rearranging the deck chairs on the Titanic: The view may be somewhat different, but the ship is still in trouble.

It is with that experience that I sit here today. I look forward, and I ask that we challenge ourselves, perhaps, to think differently and to think outside the box of our approach toward how we want to structure, look at developing and creating a system of care that allows individuals at all levels to be able to engage fully and participate fully in the communities of their choice as full and active citizens.

I often like to think about Albert Einstein and say, "We cannot solve the problems of today with the same thinking that has created them." So it is that challenge that I put forward to the committee, and essentially all of us, because it's not an "either-or" and it's not an "us and them"; mental health and addictions and the issues that surround them are something that affect us all.

I would hazard a guess that there isn't one member of this committee sitting before me today who has not been either directly or indirectly affected by a family member, a friend, a work colleague or somebody you know who has experienced first-hand a mental health or addictions problem. I would also hazard a guess that it's the same for the audience. Mental health and addiction is not a problem of us and them; it's a problem that we all have to face together. It is a challenge that we all have to undertake if we are to create a community that accepts, appreciates and honours the skills and abilities that each and every of its individuals offer.

What I would like to see, and what I am challenged to think about, is how we can go forward and create a system of care that provides opportunities for all of its citizens to be fully engaged and to participate. What we

have done in the past, and unfortunately what we seem to be bent on continuing to do, is to recreate the dynamics that really haven't worked for us in the past.

My experience as a family member, a professional and as an individual who has used service is that we have created systems of care that often make the person fit the system. We often try to make people fit into boxes that are predetermined and defined by those who may not know what it's like to have to walk through an emergency room at 2 o'clock in the morning not knowing whether your loved one will live or die the next day. We define these boxes based on arbitrarily defined systems of efficiencies, cost reduction, and what works best and what suits the system of care, as opposed to those who are seeking care.

My dream and my vision are that we would shift our focus and our way of providing care and service to really look at what it is that people need in order to live a life. Because essentially, that's what we're here to do: to try to create opportunities for people to live their lives—to live a life in the community that appreciates, honours and makes use of all the skills and abilities that people have to offer; to live a life that is free of discrimination, prejudice, fear and ignorance of the issues that they themselves may be facing; to live a life that offers opportunities that, as someone who has used or is using services, I may engage fully and optimize my dreams, goals, hopes and aspirations; and to live a life where I'm fully engaged as a citizen and I have all the rights and responsibilities that go along with citizenship. I really feel that is the challenge that is facing us today, and I hope that as the outcome or the product of these conversations that we are having here today and across the province—and, I would also deeply desire, the conversations and consultations that are about to begin as part of Minister Caplan's design to develop a 10-year strategy for mental health and addictions services—we can come to an agreement and to a collective commitment to creating a system of care that sees individuals fundamentally differently than they have often been seen.

We need to create a system of care that sees individuals not as diseased, broken or damaged people who are in need of being fixed, changed or even made normal—because, really, isn't normal a setting on a dryer? We need to create a system where we provide a continuum of care for all individuals so they can seek the supports, services and opportunities that meet them where they are, not where we think they should be, and where we provide them with the opportunities to develop skills and knowledge, and to access the opportunities that will allow them to have the life of their dreams, not just to dream about having a life.

As I reflect upon past reform initiatives, we have often spent more time focusing on how we can do things and what we need to do, as opposed to why. It is that I offer up as a challenge to all of us this morning: What is our vision and our statement of purpose for a mental health and care system here in Ontario? What is it we want for our brothers, sisters, mothers, fathers, sons and daugh-

ters, because aren't those really the people who are most directly affected? It's not some bogeyman, it's not the image that appears in movies, advertising and our popular culture of deranged individuals waiting to commit heinous acts of violence. Because if we are really able and if we really are desiring of moving forward, we also have to deal with the profound discrimination and prejudice that exist in our communities towards individuals with mental health and addictions.

I'll give you an example. During the course of my career, I've had the opportunity to travel across this province and this country giving lectures, workshops and presenting to a wide variety of groups. Unfortunately, quite often, people come to me and say, "It's funny, you don't look like somebody with bipolar disorder." My question then is, "Well, what precisely does somebody with bipolar disorder look like?" Often, people say, "Well, you're articulate, you're bright, you're smart, you're witty, you dress well and you've got nice hair." I can't compete with the Chair, unfortunately, in that regard. But really, fundamentally, what am I supposed to say to that? Really, when you think about it, mental health and addictions can strike any of us at any time.

My challenge to all of you today and to all of us is that we need to create and we need to move towards a vision of care for mental health and addictions that is rooted in the values and principles of recovery.

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As part of my brief, I have attached a document that was developed by my organization, the Self Help Alliance. The Self Help Alliance is a consumer-survivor organization situated in the Waterloo Wellington LHIN area of the province. We have program sites in Kitchener, Cambridge, Guelph and Dufferin. What we did is we developed a vision of what we thought the system could and should look like. A few years ago, the Ministry of Health invested some funding into the case management services in our area, and there was a conscious decision by our system to say we need to provide service that is recovery-oriented. As those who are most directly affected by service, we said, "If that's the case, then this is what it's got to look like."

A recovery-oriented mental health and addictions system will value empowerment, value and instill hope, value self-determination, work towards the elimination of prejudice and discrimination, and value meaningful choice. To that end, we also said that the system will embrace and focus upon the principles of promoting the development of skills through personal development, the development of the system, and the ongoing involvement of those who use service in the implementation, planning, development, governance and evaluation of the service. We also said that the community will value each and all of its citizens and provide supports and opportunities for engagement. The most critical thing is that we have to create a system that instills and promotes hope, that encourages people to see a life beyond the system. It is not something like the Hotel California, where you move in and you never check out. We must provide oppor-

tunities for people to be able to dream, to aspire and to have a life as a full and active citizen.

I'll leave you with a quote by George Bernard Shaw, that being, "Some men see things the way they are and ask, 'Why?' I dream of things that never were and ask, 'Why not?'" It really is the challenge of, "Why not?" What do we hold as possible and what do we believe is possible?

It is with that end in mind that I would challenge us all to spend less time, perhaps, figuring out what we need to do and how we do it, and perhaps more time saying, "Why are we doing what we do?"

I look forward to your comments and questions.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much, Allan. You have left some time for questions, which is wonderful. We'll start with France and then go to the government side.

M^{me} France Gélinas: It was a pleasure to hear your presentation, Mr. Strong. I tried to follow as best I could.

When you talk about wanting a new system that helps everybody be engaged in the community, but you also recognize the profound discrimination and prejudice against people with mental illness, do you really see this as part of one, as part of the mental health system?

Maybe I'll talk for myself. I had this preconceived idea that society needs an attitude adjustment on how to deal with the discrimination and prejudice, and then we need to work on our mental health system so that we can support people through their recovery no matter where they are at. You seemed to put the two together, and I was wondering if I heard that wrong, or did you say that?

Mr. Allan Strong: No, the two definitely go hand in hand. Not only do our society and culture need an attitude adjustment, but unfortunately the system itself needs an adjustment.

The Schizophrenia Society of Canada did a study a few years ago which indicated that some of the most profound discriminatory attitudes that exist towards individuals in mental health actually exist with the workers in the system itself. I think we really have to look at challenging values, beliefs, and the mythology of what people with mental illness not only are capable of but what they're not capable of. I really think that it goes hand in hand. It's not an either-or; we really have to look at tackling the issue of discrimination at all its levels, wherever it exists, both in the system and outside.

M^{me} France Gélinas: Do you have any direction for us as to best practices or other jurisdictions that have made some significant strides toward tackling the prejudice and the discrimination that we find?

Mr. Allan Strong: One of the most interesting documents I read was some research that was done in the United States. It's often assumed that by education alone we can address discrimination, but unfortunately, what they found was that over the long haul we may have more information and better information about mental health, but still, people's attitudes and beliefs don't change. They find that the most significant way to change people's attitudes and beliefs is through personal

contact. So then it becomes somewhat of a paradoxical situation: If we have an environment which doesn't encourage people to come forward, how do we get people to come forward?

So it's through research that we find that personal contact and education is often the best way to change attitudes. The challenge is, how do we create the environment to allow that to happen?

The Chair (Mr. Kevin Daniel Flynn): Thank you, Allan. Helena's next.

Ms. Helena Jaczek: Thank you very much for your overview. I agree with you totally in terms of this idea of an overarching vision and a system of care that fosters hope, that type of an approach, and has the primacy of consumer choice at its centre. I suppose, from the perspective of a self-help alliance, there would be an acknowledgement from yourself of a need somehow for those who are experiencing mental ill health, to put it in some sort of frame that perhaps you could accept, that there's a need for assistance in navigating the system—or non-system, such as it is—in terms of allowing you that kind of choice.

I suppose what I really am trying to get at is, have you seen any models that, with your vision, assist an individual in navigating the non-system that we have that work really well? We've heard a little bit about intensive case management; that sounds very intrusive. Is there something that you've seen out there that sort of meets the needs of a self-help alliance within this vision of consumer choice?

Mr. Allan Strong: Well, it's interesting. We have a proposal and a suggestion to our local LHIN to do what you're talking about with the establishment of peer navigators, which would be people with the lived experience to provide support, education and an opportunity to walk beside somebody.

There's a model in Maine. There's a consumer organization in Maine that has peer support people in the emergency department of the state hospital, and they see over 50% of everyone who walks in the door. There are also examples of peer navigators in various pockets in the States, in Connecticut, I believe. There are also peer advocates in every hospital in Ireland. These are, essentially, people who have the lived experience and provide that context.

I also work part-time for the mobile crisis team in our area, and I recognize—and having been through the system myself—that there are times when you do experience distress and you do need support. That's a given. It's not an either-or. How do we create and how do we provide a continuum that provides people service where they're at?

The limited research that has been done on the idea of having peer navigators says that that's one model and one way we can approach that, that we have somebody who's been there, who can say, "I know what you're going through, and perhaps I can provide you with some information or a different way of looking at things that can help you come to a better understanding of what it is you're going through."

Sherry Meade, who is an MSW, a writer and a consultant on peer, says that peer support is trauma-informed. Understanding the trauma is a way of providing a different context for your experience and providing opportunities for you to emerge from that experience, perhaps with a better understanding and a different way of approaching things.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Allan. We really appreciate your presentation today. Unfortunately, the time is up. You used your time perfectly; it just turned 10 o'clock. I have a very public clock here today.

Thank you very much for coming today.

GABY WASS

The Chair (Mr. Kevin Daniel Flynn): If we can call up the next delegation, Gaby Wass. Come on forward. Choose any microphone you're comfortable at. Like all the other delegations today, you've got 20 minutes. You can use that any way you see fit. If there's any time left over at the end, perhaps we can ask you some questions. Welcome.

Ms. Gaby Wass: My name is Gaby Wass, and I'm here to share my story in the hopes that together we can move forward in helping Ontario a better place for our children and youth.

My journey begins with a birth announcement that reads as follows: "The day was cloudy and rainy, yet ours was filled with sunshine, having been blessed with the birth of our daughter Amanda Iris." Amanda enjoyed almost four fantastic years in life. She walked at nine months, was toilet trained by her first birthday, was reading early reader books and speaking in full sentences by the age of two. At three years old, she was singing Céline Dion songs better than Céline herself.

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Each June, before her birthday, we had portraits taken of the kids so that I could give them to friends and family at her birthday party. The portrait in 1997 shows her happy smile, her bright eyes and her sweet personality shining right through the photograph. That would be the last photograph of my little girl lost. By September 1997, her school pictures begin to show the haunting tale—the smile is gone, the dark circles under her eyes and the genuine sorrow which we can only see in hindsight. In November 1997, Amanda discloses to her father that she is being abused by a close family friend.

Our first involvement with an agency is CAS, as part of the police investigation of the crimes committed against my children. After a thorough investigation, I am found to be negligent for over-bathing my children, and my husband is questioned at length for loving his daughter too much. If only love alone could have saved her.

CAS protocol at the time is simple: The child must now attend a crisis intervention program with other child victims of the same such crimes. My daughter, at barely four years old, is the youngest participant, and I see the

horror in her eyes after each session. These much older children are sharing some pretty graphic details about their own abuse. Not one to question authority, I assume they are the experts and they know what is best for my child.

By 1998, the school is calling to ask me to send a change of clothes to school with Amanda, as she is at times showing up with soiled pants. I was later able to determine that being on the bus with a male bus driver is what caused her to urinate in her pants. Incidentally, at this time, she is also beginning to withdraw from her father, with whom she had been very close. The school is also reporting that Amanda hides under her desk when a man enters the classroom. Amanda will not sleep unless her father and I are in bed with her. We purchase a king-size bed to accommodate our new nightly guest.

Her teacher finally suggests that perhaps I take Amanda to a therapist. The fact that the therapist is a man further exacerbates her anxiety, and it is only in hindsight that I realize I further contributed to her trauma. After repeated sessions in silence, I decide I cannot afford to spend the money with no gains, and Amanda certainly is not being engaged.

In 1999, I seek out an art therapist and, after only one session, am told that Amanda is not ready for this type of work.

In early 2000, Amanda's teacher calls to address some concerns she's having about her—namely, Amanda's daily routine of throwing out her lunch as soon as she walked into the classroom; the strange animal noises she made in class, which often frightened the other children; and the fact that she was hearing and seeing things that others could not see or hear. In a barely audible whisper, she says, "Mrs. Wass, I think your daughter is suffering from some sort of mental illness, and she needs help."

I make arrangements to have my daughter begin play therapy. My initial appointment with the therapist I attend alone, and share with her the details I had learned at trial about Amanda's abuse. I advise that my daughter gave her father very surface information which led to the arrest of the perpetrator, but Amanda never told us the details about the horror herself. Several visits later, the therapist tells me that she just can't seem to get through to Amanda and asks me to attend the next session with my daughter. We arrive at the appointment, and the therapist has two anatomically correct dolls and asks Amanda to tell her about what happened to her. To my complete shock, the therapist begins to relay, in detail, her own abuse as a child, and says, "See, it's okay. I'm okay. We can talk about it." With silence hanging heavy in the room, the therapist begins to re-enact the details I had shared with her about Amanda's abuse. Amanda unleashes a guttural scream and runs out of the office. We get into the car, and as I am putting on my seat belt, Amanda tells me, with a very blank look on her face, "Mommy, I hate you, and I wish I was dead." Sobbing the entire way home, Amanda attempts to jump out of my car while it's in motion. I pull over and ask my husband to pick us up. Amanda enters her room, I give her a few

minutes to herself, and am appalled to walk in on her banging her head on the floor and two fistfuls of her own hair. She repeats over and over, "I wish I was dead. I wish I was dead." At six years old, my daughter wants to die.

Incidentally, my son is diagnosed with neurofibromatosis, and a family support worker from the Elgin Association for Community Living is assigned to our family. Darlene Siddall becomes our rock during the toughest of times. By this point, Amanda's mental health is in such a decline that we cannot go out in public. People stop and stare or make rude comments as Amanda bites herself, bangs her head against the walls or displays other alarming behaviours. We have effectively become prisoners in our own home.

Darlene tells me about CPRI, and I call in a self-referral. Amanda is assessed, and the initial findings determine that Amanda has PTSD, early onset anorexia and possible dissociative disorder. The recommendation made is a treatment placement. My husband and I agree that Amanda would likely benefit from an intensive-type intervention. Amanda is placed in a program at CPRI.

Amanda thrives in this artificial environment and within weeks, the initial diagnoses are kiboshed and replaced with conduct disorder and ADHD. The cause: poor parenting. My husband and I are sent to parenting classes. We are thoroughly confused. We have two children being parented the same way. One is thriving; the other child is languishing. However, the problem is determined to be our parenting. We rely on the expert opinions and do as we're told. Amanda is discharged 90 days later. Her first night home, she climbs on our roof and threatens to jump. Within days she is back to head-banging, biting herself and pulling out her hair. Darlene assures us that we are great parents and that Amanda needs professional help. We seek out services within our local children's mental health agency and are told that Amanda does not have mental health issues. In fact, if we would just put her on Ritalin, we would be able to better control her. Once again we do as we're told. A local pediatrician prescribes the medication. The medication has no effect on Amanda.

In 2001, Amanda begins to see her school social worker, but no gains are being made. We don't know what to do; we don't know where to turn. Darlene remains our pillar of strength and encourages us to be hopeful. My strength is fading by the day and I wonder how we'll make it through another minute. Darlene says to me one day, "Gaby, find your strength. Your daughter's future depends on it."

In 2002, Darlene tells us about Madame Vanier, and once again we reach out for help to yet another agency. The supervisor, a kind man, tells me that he has been in the field for many years. He relays that a small percentage of the population is untreatable. Based on Amanda's case file, he believes Amanda to be in that small percentile. She has been left to languish far too long.

My heart refuses to believe him, and after four months of treatment, the supervisor tells us he has never met two more committed parents who have gone above and beyond in an effort to seek appropriate treatment for their child. My husband and I voluntarily take parenting classes in an effort to gain insight into how to deal with the new behaviours. He commends us on the work we do as parents and recommends that Amanda be placed in a long-term residential treatment program if there is to be any hope. Amanda leaves this agency in August 2002 with confirmation of PTSD.

By December 2002, my husband is calling children's aid for assistance. Efforts are made to have respite services for Amanda. However, that placement does not work out, and we are left with no open doors and continue to suffer in shame and silence. In May 2003, CAS advises that they have found a long-term treatment program for Amanda that truly believes they can help her. The only catch is that in order to access the treatment bed, Amanda must become a crown ward. On June 10, 2003, my husband and I appear before the courts and abandon our parental rights. We later learn that this was the first time a child was turned into a crown ward to access this mental health treatment. Days later, CAS apprehends Amanda from our home and transfers her to this program, three hours away from home. I contemplate suicide that day, feeling like I have failed my daughter terribly.

I show up on the doorstep of the agency supervisor, who tells me that there is little hope of recovery for Amanda. He listens as I sob and he assures me that my husband and I have done everything humanly possible, and what we did by abandoning our rights was clearly a sign of tremendous love for our child. I return home and spend days unable to get out of bed. Contact with our daughter has been severed and the battle to reinstate our right to access is exhausting.

The treatment home is in a dilapidated neighborhood in a poor state of repair. Within months, Amanda's condition is worsening. Her hygiene is appalling, she is frequently assaulted by other residents, her clothing and shoes are stolen, and she begins cutting and running away. On one of her escapades, she jumped out her second-storey window and broke her foot. Three days after complaining of terrible pain they finally take Amanda to the hospital, but only after my lawyer sends them a letter. I am appalled; I wouldn't leave a dog to limp on a broken foot for three days, let alone a child. Eighteen months into her placement, there has still not been a psychiatric evaluation, nor have counselling or treatment commenced.

In 2004, I decide to quit my full-time job to become a full-time advocate for my daughter. I begin having conversations with the Office of the Provincial Advocate for Children and Youth and the Ombudsman's office. In 2005, the Ombudsman releases a report entitled *Between a Rock and a Hard Place*, and that document results in the immediate restoration of our parental rights. We immediately begin the process to transfer Amanda back to

Madame Vanier. Incidentally, that report ceases the forcing of families to give up their rights of access for treatment of any kind for their children.

1010

In August 2005, Amanda returns home. The recommendation at this time is that Amanda be placed into long-term-treatment foster care. We have promised Amanda to never place her outside the home again. I am baffled as to why the ministry would pay exorbitant amounts of money to keep Amanda out of her home but will not wrap services around her to keep her at home, which she so desperately wants. The effects of the separation have been hard on the entire family. Amanda has become so disengaged that she won't even eat meals with us. She just doesn't feel like she fits in. She spends a lot of time alone in her room listening to music and reading. She has become isolated and ostracized in her community. She refuses to engage in therapy, and life at home is a living hell.

In 2007, Amanda enters high school, and I suspect that she is self-medicating with drugs and alcohol. My family doctor sends her for a psychiatric evaluation, and once again she is diagnosed with PTSD, and this time also depression. She is put on antidepressants and seems to fall into a black hole that we can't get her out of. She talks constantly about killing herself, is cutting, binge-eating and purging, writing dark poetry and becoming physically combative with me.

In January 2008, I call a crisis line of the agency for Amanda's last psychiatric evaluation and tell them that something is terribly wrong. I have taken her countless times to the local hospital begging to help me save my daughter's life. Amanda does not meet the criteria to be put on a Form 1, and we are sent home over and over again. The crisis line agrees to present Amanda's case at the morning meeting to see if she can access an urgent response bed in their secure lockdown facility to undergo an intensive psychiatric evaluation. Within 24 hours, I have a return call that a bed will become available for Amanda the following morning. I am instructed to appear before a judge to get a Form 1. The judge hears my story, signs the form, states he wishes there was something more that he could do to help and wishes me well on my journey. My husband and I transport Amanda to the facility against her will, and she is placed in an isolation unit as she is unmanageable even by their highly trained staff. They wonder how we ever managed her at home, and I relay that it has not been easy.

One of the hardest parts was living a double life. To the community at large, we appeared to be living the Canadian dream. We were living in what one reporter called "an affluent neighbourhood in an immaculate home." Financially, we appeared to be doing well. We drove nice cars, had a boy and a girl, and seemed so happy. Even our closest friends didn't know what was happening behind closed doors.

The facility diagnoses Amanda with PTSD, reactive attachment disorder and bipolar. The psychiatrist explains that a traumatic experience can trigger an onset of

bipolar, and that RAD has likely developed due to the multiple placements beginning at such an early age. The psychiatrist advises that if Amanda is to have any success, the community must be prepared to act in a timely fashion. He recommends that Amanda be returned home, that supports be placed in the home for 59 hours a week, full-time support at school, ongoing psychiatric care and therapy. The only recommendation that our community is able to pull together is the full-time support at school.

Amanda's discharged in February and rapidly begins to fall apart without the services to support her. It is exactly what the psychiatrist predicted. Amanda runs away from home in March and somehow bulletins appear on the radio 24 hours later: "Amanda Wass of St. Thomas, age 14, last seen wearing ..." Our friends think there has been some sort of mistake; after all, we have the perfect life and are the envy of many. Slowly our secret life is exposed, and in anguish we share our story. My friend Marianne Watson contacts the London Free Press, and I agree to allow our story to go public.

My shame is not mine alone to shoulder. The province of Ontario has neglected my daughter, and I'm tired of my secret life. My daughter is eventually found after our family, friends and police conduct a door-to-door search. Amanda is taken to an adolescent psychiatric unit at a hospital in London, and two days later we're asked to come pick her up as she is unmanageable and they don't know how to help her. She returns home with a confirmed diagnosis of PTSD and bipolar. A referral is made to the WrapAround program and CPRI. A few weeks later, Amanda runs away again. Police don't know what to do with her. The hospital doesn't know what to do with her. Ambulance attendants refuse to take her in their ambulance. My husband and I don't know what to do with her, and CAS cannot technically become involved, as she is not a child in need of protection.

I Google "children's mental health," "youth mental health" and "mental health in Ontario." I develop a list of 432 people who are somehow connected to mental health. I have stationery made up with a picture of my daughter on the left-hand side of the envelope and a picture of my daughter as the letterhead. I beg somebody to help me save my daughter's life. I receive calls from Ian Manion, Simon Davidson, Gordon Floyd and Barry Evans, to name a few. They applaud the extraordinary lengths I am going through to access service and share the dismay in the current crisis of children's mental health in Ontario.

In the meantime, our first WrapAround meeting occurs. Our initial team is about 40 people. I candidly share that one of the options I have considered is murder-suicide. I cannot stand to watch my daughter continue to suffer and I have exhausted all our resources. I beg the team for help. The initial meeting occurs on April 21, 2008.

My parents got to hear from the professionals involved with our family, from our friends who had witnessed the cruelty of the last few months, the educators who had

done everything humanly possible, the therapists who just didn't know what to do. My stepdad went to work the next day, quit a supervisor's job he'd had for 14 years and called to tell me he was leaving Toronto and coming to help me. He left his friends, his job and even my mother. He apologized profusely for not having seen through my charade and allowing us to suffer in silence. He said, "Gaby, it will be a shared responsibility. I'm here to help you now."

With help from many people, we were able to access 20 hours a week of in-home support. Sadly, it was not enough time to stabilize Amanda in the home and the help had come too late. Amanda was re-hospitalized in May 2008, transferred to an urgent response bed at CPRI in June 2008, and transferred to Anago Girls' Home in Parkhill in September 2008, and continues to reside there. CPRI has confirmed the diagnosis of PTSD and bipolar. A psychiatrist recently told me that Amanda will likely spend the rest of her life institutionalized. Her story did not need to end like this. There were 11 years of missed opportunity.

I may be too late to help my own daughter, but not too late to help others coming behind her. I now spend my time sitting on various committees pertaining to children's mental health in my community. I sit on the provincial board of Parents for Children's Mental Health, I help families and children navigate the system, I attend conferences in an effort to better educate myself, and I speak to the media and will do whatever it takes to bring this matter out of the shadows forever.

My recommendations:

- Don't be so quick to point the finger at the parents. We are the experts in our children.

- Create navigator positions so we can help other parents navigate the maze of services.

- When we reach out for help, don't slam the door in our face. Help guide us in the right direction to do right by our children.

- Wrap services around the child and not the child around the service.

- Stop taking kids out of their home for treatment. Bring the treatment to the child's home and allow them to have the inherent benefits of loving and stable families.

- Find creative ways to collaborate with other agencies already involved in our life.

- Connect us to peer support groups, as someone with lived experience can often help us best in times of despair. They know best; they have walked in our shoes.

- Don't turn things into a power struggle. We are all in this together.

- Most importantly, hear our voices and allow us to help you through consultation and implementation phases. We have lived experience, which is very valuable.

Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Gaby. Unfortunately, you haven't left very much time, but perhaps I could ask one question. What should have

happened? What was the very first thing that should have happened?

Ms. Gaby Wass: When I was explaining to the therapists what the behaviours were that Amanda was exhibiting, perhaps they should have taken a closer look at the behaviours as opposed to our poor parenting, which at the end of the day was not the cause of her mental health issues.

The Chair (Mr. Kevin Daniel Flynn): So how old was Amanda then?

Ms. Gaby Wass: Four.

The Chair (Mr. Kevin Daniel Flynn): She was four. Okay. Thank you very much for coming forward today. It's really appreciated.

DONNA BOWERING

The Chair (Mr. Kevin Daniel Flynn): Our 10:20 appointment is Donna Bowering. Is Donna in the audience yet? Donna, please come forward, then. Make yourself comfortable.

Ms. Donna Bowering: Like a lot of these people, this is the first time for me in front of a committee.

The Chair (Mr. Kevin Daniel Flynn): We're all friendly people.

Ms. Donna Bowering: I know you're friendly.

The Chair (Mr. Kevin Daniel Flynn): If you'd like any water, I'm sure we can arrange to bring some water for you. We're just talking about that; we don't have any there, but I'm sure we could arrange it.

Ms. Donna Bowering: It's okay, I brought some in my purse. And can you hear me okay?

The Chair (Mr. Kevin Daniel Flynn): Oh, yes, we can hear you fine.

Like everybody else, like Gaby before you, you've got 20 minutes. You can use that any way you like. If there's any time at the end, maybe we can ask some questions.

1020

Ms. Donna Bowering: Okay. I'd like to begin. This is my story: My name's Donna Bowering. I picked up my first drink when I was 13 years old and I put down my last drink at 38. One drink did something to me that, within one year, I had no control over. I believed I was the perfect image of a wife and mother. Before too long, I crossed what was an invisible line from social drinking to full-blown alcoholism.

I have three daughters, a wonderful husband and six grandchildren. None of this would have been possible if I hadn't gotten honest with myself. I vowed I wouldn't drink every day or drink in the morning, but eventually I did. My girls would come home from school and wouldn't know which mom was at home: the drunk mom or the sober mom. I tried every day not to drink, praying to God, "Not today, not today," but each time I lost the battle and I picked up the drink, usually to take away the guilt and remorse from the night before.

I learned later in my recovery that an alcoholic's willpower alone, however strong in other respects, was not enough to keep me sober. I remember one day my

oldest daughter was in her room packing a suitcase. She was leaving home. I was upset and hung over from the night before. She said, "I can't do this anymore, Mom." I told her that I loved her; she didn't say it back. I told her again, and nothing. Her friend said to her, "Tell her you love her." My daughter cried and said, "I can't," and she left.

A few months later, my middle daughter left also. My youngest daughter was too young to leave; however, she told me years later that she asked her sisters to take her with them. My husband and I fought all the time about the drinking. You see, I lived in a beautiful home with five people, but I felt I lived alone, all because of the abuse of alcohol.

Six months prior to arriving in recovery, I had a doctor's appointment. My doctor wanted me to go with him, so I followed him into a large room. In this room were my husband, daughters, parents, sisters and brothers. It was an intervention. I was so angry I folded my arms in disbelief. The doctor said to me, "Donna, your family is here because they're concerned about your drinking." My father was the first to speak. Tears rolled down his face. He said, "Donna Marie, we love you. Please get some help for your drinking." I never saw my father cry before. Tears rolled down my face and I unfolded my arms. Everyone in that room shared with me that day about my drinking. The doctor asked them to leave so he could speak to me and my husband, but as each one left, each one of them told me that they loved me, even the two daughters who had left home, who couldn't find it in their hearts to say those words the day they left.

Within six months, I was a patient at the Homewood Health Centre in Guelph. I stayed there for eight weeks, learning the guidelines to my recovery. I learned how it happened and what I could do about my addiction. November 25, 1994, was the first day of the rest of my life. The first thing I learned about alcoholism is that it is one of the oldest problems in history, described as a physical compulsion coupled with a mental obsession. Dr. Bob Smith and Bill Wilson were the two co-founders of AA, Alcoholics Anonymous, and the 12-step program back in 1935—two alcoholics helping each other. There are 78,000 local groups in 114 countries.

Alcoholism is a worldwide problem, but most importantly, it is here in our own city of St. Thomas. I moved to St. Thomas three and a half years ago from a small town called Mount Brydges. I started an AA meeting in Mount Brydges eight years ago. This meeting is packed every Friday night with alcoholics wanting to get well. Not everyone succeeds, but if I hadn't gotten honest with myself, this small town would not have an AA meeting for men and women to share their experiences and hopes of recovery.

When you stand inside an AA meeting, you hear laughter. That is the basis of recovery. Outside these meetings, the recovering alcoholic/addict feels fear and loneliness.

Today, I live life on life's terms: clean and sober. I sponsor seven women who are all mothers. I'll share with you one of these stories of one of these moms who called one night, crying and drunk, who wanted to quit drinking. She replied, "I'm not a welfare mom. I have my kids. I have a nice home." I told her, "You keep drinking like you are and you will be a welfare mom." Sure enough, she did go on welfare and is losing her home because of her drinking. Eventually she surrendered, and she has been sober for one and a half years. You see, when you help a mom or dad, you help the whole family, my own family being a prime example. A judge once commented in the St. Thomas Times-Journal, "You poison people, you poison families." How true that is.

Alcoholics are everywhere. If you haven't been touched by someone's drinking or drug use, ask yourself, what would you like to be available for your son or daughter, parent, friend, husband or wife etc., if it happened to you? When I was in Homewood Health Centre, there were moms, dads, judges, psychologists, teachers, police officers and even a Catholic nun. This disease can affect any profession and any age group.

In my sobriety, I try to go beyond sobriety. Just not drinking—that was only the symptom to a bigger problem. Recovery is an inside healing job.

Anything that works toward recovery for the alcoholic and the addict is good, and this includes hospitals, rehabilitation centres and detox or recovery houses. St. Thomas has daily AA meetings and two NA meetings. Twelve steps and aftercare are the tools they need to live a sober life. Doctors provide prescriptions; recovering alcoholics provide the help.

Presently, there are no accommodations for these individuals to attend. Only church basements are accommodating the alcoholics for AA meetings. A lot of alcoholics and addicts have to detox in our hospital emergency areas before entering a recovery facility.

I believe that with the introduction and co-operation of the aftercare treatment facilities, it will serve to the benefit of the community of St. Thomas with resources to help the alcoholic and the addict. With education, counselling and rehabilitative treatment, it will help the community to be aware of people still suffering from the deadly disease that AA has helped us arrest.

This is my story of what alcohol has done in my life and where recovery has taken me. I know I've played an important role in the lives of others, and I wish to continue to do so. An older gentleman from Texas who I met in AA told me once, "We are the chosen few."

I have recommendations I'd like to address to the committee.

- (1) Provide a drop-in centre where information can be provided, as well as counselling.
- (2) An increase in rehabilitation centre space.
- (3) Easier access to rehabilitation centres.
- (4) A recovery house after leaving a rehab centre. The gap between recovery which I experienced when I left Homewood—I remember my husband taking me home, and he said, "Why are you so quiet?" I said, "I'm

scared," because in that place I felt safe, but what I learned is I had to take it out there and I had to start walking it and talking it.

(5) Provide a detox centre with medical supervision.

(6) A safe environment to teach life skills through agencies, professions and recovering alcoholics.

In closing, I'd like to thank you for your time and invite you to take a prepared copy of my submission from today. If you have any further questions, please feel free to contact me at any time. Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you for coming forward today, Donna. You have left some time for questions. Anybody over there? Liz?

Mrs. Liz Sandals: I'm just curious. I happen to be the MPP for Guelph, so I know the Homewood very well. Were you there as a private patient or a public patient?

Ms. Donna Bowering: I had insurance through my husband's company. It made it a lot quicker for me to get in. That was almost 15 years ago, and I don't know what the changes are now, but OHIP will still—

Mrs. Liz Sandals: It's still the same situation, which is why I'm asking.

Ms. Donna Bowering: Yes. It just takes a lot longer to get in, and I know at that time there were 80 beds, and those 80 beds were full.

Mrs. Liz Sandals: Yes, and that was the reason I was asking: Did you have to wait a long time, which is true in a public bed—

Ms. Donna Bowering: Not with insurance.

Mrs. Liz Sandals: You got in quickly. Thank you.

The Chair (Mr. Kevin Daniel Flynn): Anybody else?

Let me jump in. Just so I understand the 12-step program, there are people who talk about a harm-reduction model, and there are people who talk about an abstinence model. The AA program, the 12-step program, is an abstinence model. Is that right?

1030

Ms. Donna Bowering: Yes.

The Chair (Mr. Kevin Daniel Flynn): Do you find that there's any conflict within the profession about which way is better or do you find that one is in style for a while and one is not in style? Do you run up against that?

Ms. Donna Bowering: I'm not sure if I understood your question, but I'm going to explain something to you. Prior to getting into Homewood in Guelph, after the intervention, I had gone to a centre to be evaluated for my alcoholism. The counsellor I had—you have to understand, when you're an addict and an alcoholic and you have to give up something that has been so strong in your life—this counsellor said to me, "I don't think you're a full-blown alcoholic, so I'm going to teach you how to drink socially." That was the best news I heard. Believe me, I wanted to quit, because those people who were sitting in that room, just like a table like this—you know, they say no human power can restore you from your alcoholism. Those people in that room tried, but when that counsellor told me that he would teach me how

to drink, I thought, "Oh my, I'm going to make everyone I love happy, I'll make me happy and I'll be able to drink socially."

The Chair (Mr. Kevin Daniel Flynn): It doesn't work that way.

Ms. Donna Bowering: It can't happen. When I ended up in Homewood—I pay no disrespect to that counsellor, but I called him and I said to him, "Hi, I'm Donna Bowering. You counselled me prior to getting into Homewood in Guelph, and you cannot teach an alcoholic how to drink." He said, "Well, I'm sorry," and I said, "I just had to tell you that." Abstinence is the key. Even last night at the meeting, when you substitute alcohol for a drug or a drug for alcohol, they're both the same. It's abstinence.

The Chair (Mr. Kevin Daniel Flynn): Okay, that answers my question. Thank you, Donna. Sylvia?

Ms. Sylvia Jones: Thank you for coming, Donna. I noticed that you have used your life experience, and you're now sponsoring seven people?

Ms. Donna Bowering: Yes, I am.

Ms. Sylvia Jones: Is that, for you, a critical part of your rehabilitation? Tell me more about why that's so important to you.

Ms. Donna Bowering: It's like I said: A doctor will prescribe prescriptions, an alcoholic will help an alcoholic. The two gentlemen who started it back in 1935 were two men, two alcoholics. Drinking has been a problem, but these two men helped each other. From that, it continued.

When I sponsor women and they're calling me or I'm counselling them, I always say to them afterwards, "Thank you." I had one lady say, "Why do you say thank you?" and I said, "You do not know how much you are helping me." I don't want to get complacent in my recovery; I want to remember where I came from so I don't go back there. They give me a gift, and that's why only an alcoholic can help another alcoholic.

A mother I sponsored for one year got her one-year medallion with all her family there, and her older daughter came up and she said, "Donna, we tried so hard; we tried so hard. Why did she listen to you?" I said, "Sweetie, her heart listened to you, but I'm an alcoholic, and I help your mother because she's an alcoholic. I know how she thinks; I know what she feels."

Ms. Sylvia Jones: Thank you.

Ms. Donna Bowering: Thank you.

The Chair (Mr. Kevin Daniel Flynn): France?

M^{me} France Gélinas: Thanks, Donna, for sharing your story. I was a little bit puzzled as to why it took so long. How come when your daughters left, there wasn't an intervention then? Basically, you're talking about 25 years. There are a lot of days there; there's a lot of opportunity for change. How come it didn't happen when your daughters were born? How come it didn't happen when they left?

Ms. Donna Bowering: That's a good question. Do you know what? That's why it took me so long to get into recovery. Alcoholism and drug addiction is a

physical, mental and emotional obsession. I pay no disrespect to the panel, but unless you've walked it, you don't know. I think Mr. Strong was saying too that you don't know what you're dealing with unless you've been inside that box and you know what they're feeling and thinking. That's why for me, as a mom, I tried so hard to fight, to not drink today, and I thought it was willpower and I thought I was weak. But the physical, mental and emotional obsession of this disease just festered inside of me, and—I think about this daily—when it came to my family and it came to the drink, the drink won every time.

For me, when I hit my bottom—my children are my life; my family is my life. When it came to me at the bottom and I hit my bottom, I was very depressed, and I tried to kill myself because I thought, "I'm a bad person. I'm not a good person." Something so powerful as alcohol was controlling my life, and I couldn't understand why. I looked into the eyes of those children and I thought to myself, "No. I can't do this anymore." And that's the power of the disease of alcoholism and addiction. It is hard to understand if you're not an alcoholic or an addict, but it is an overpowering compulsion.

So I guess my meaning here today is just to explain to people that this destroys families. When I said this in my presentation—when you help a mom or someone's helping a dad, you're helping those families.

M^{me} France Gélinas: I'll ask you a personal question, and you certainly don't have to answer. When you were pregnant, didn't anybody talk to you about your alcoholism? Didn't they offer treatment then?

Ms. Donna Bowering: No. I always say this, and everybody says, "But why do you say this?" Because people do drink when they're pregnant. I was pregnant three times, and I had this life inside of me, and I did not drink.

I was, at one time, a social drinker. My first husband was a full-blown alcoholic. When I went back home to Quebec to visit his family and friends, I was offered a beer, and I said, "No, I'm a member of Alcoholics Anonymous and I don't drink anymore," and they said to me, "When did you start?" There's a line that you cross, as an alcoholic and an addict—as I always say, the invisible line. You have control over something, and all of a sudden you cross over and it's got control over you. So when I was pregnant, no. As God is my witness, those children were my life and I would never have jeopardized them. But the disease, when I crossed over, took over my life and my family.

That's why I'm here today: to tell you that getting into recovery is great and it saved my life, but when I got out, I didn't know what to do. And this is what I'm trying to teach these moms: that there's more to life than just going to the meetings—which I'm 100% on board with—and to teach them how to live life on life's terms, to start to be a mom again.

M^{me} France Gélinas: I guess what I'm trying to get at is, because of the 25 years it took, were there opportunities missed there? Were there other times when you would have been ready to go into recovery, but those

opportunities were missed? You said you had a family physician; I'm sure at some point he or she must have asked you if you drank, and didn't that trigger some action? Twenty-five years is a long time.

Ms. Donna Bowering: I know it is. And you're right: The physician did ask me, "How much do you drink?" And you know what? It's a cunning, baffling disease. Trust me, when you're sitting in a seat like this across from your doctor, you're not going to tell him what he wants to hear. You're going to tell him what you want him to hear.

One of the things I did when I went into recovery was meet with that doctor, and I said to him, "I owe you an apology." And you know what he said to me? "No. You taught me a lesson. When I'm sitting there and I've got somebody as smart as you who thinks that they're getting away with it"—so I fooled the doctor. For all those years, I fooled the doctor.

My husband said to my own mother, "I didn't even know it was going on in the house," because he—you know, it's a sneaky, secretive thing that goes on. He said, "She had it down underneath her lacy, curtained table there." We try so hard to hide it. It's cunning and baffling and powerful, and we will—it sounds horrible, and it breaks my heart every time, but we choose it over what we need. So they didn't know.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Donna. Thank you very much for coming today.

Ms. Donna Bowering: Thank you.

ALZHEIMER SOCIETY OF ONTARIO

The Chair (Mr. Kevin Daniel Flynn): Our next scheduled presenters are the London Health Sciences Centre and St. Joseph's Health Care. I understand that only two of the three presenters are here, but the Alzheimer Society is prepared to go ahead. David, if you'd like to come forward. It's good to see you again. Why don't you find a comfortable place to sit? Like everybody else, you have 20 minutes, and you can choose to use that time as you see fit. If you'd introduce your colleagues for Hansard, that would be great.

1040

Dr. Jane Rylett: I'm Dr. Jane Rylett. I'm a professor at the University of Western Ontario and the chair of the department of physiology and pharmacology in the medical school. I'm also an Alzheimer's disease researcher, and have been for more than 25 years. I'm a member of the board of directors of the Alzheimer Society of Ontario, and previously the Alzheimer Society of Canada. So I'm here as a representative of the board of the Alzheimer Society of Ontario and as a researcher.

Mr. David Harvey: I'm David Harvey. I work with the Alzheimer Society of Ontario, serving as the interim CEO at the moment.

Ms. Shelly McCorkell: I'm Shelly McCorkell, and I'm the executive director of the Alzheimer Society of Elgin-St. Thomas. I'm very pleased to be here today.

Mr. David Harvey: Dr. Rylett is going to start our presentation.

Dr. Jane Rylett: Thanks very much, David. It's a large privilege for us to be able to speak to you today on behalf of Ontarians affected by dementia—those individuals affected today and those individuals who will be affected in the future.

We'd like to deliver a very simple message to you. First, the demographics of dementia can overwhelm the health care system unless we're prepared to deal with it. Second, the essentials for preparedness are already in place; it's just a matter of making use of them and expanding upon them. Third, a comprehensive response to dementia involves all of us, and in particular, the mental health care sector.

I'd like to tell you just a little bit about the Alzheimer Society. The Alzheimer Society of Ontario is one of the provincial members of the Alzheimer Society of Canada. It was founded in 1983 and supports a province-wide network of 39 chapters. These chapters and members are committed to improving service and care of individuals with dementia; funding and advancing research into the causes, cures and treatment of Alzheimer's disease and dementia; education in the community that is served by the Alzheimer Society; and finally, creating awareness and mobilizing support for the disease and related dementias.

Our society's vision is a world without Alzheimer's disease and related dementias. We're affiliated with the Alzheimer Society of Canada, as I mentioned, and also with Alzheimer's Disease International. In the spring of 2011, the Alzheimer Society will proudly welcome people from 71 countries to the 26th Alzheimer's Disease International conference in Toronto.

Alzheimer Society chapters provide a range of services, including group support, counselling, information and education, public awareness and dementia-specific education for front-line health service providers. Some also provide day programs and respite care for caregivers.

The Alzheimer Society of Ontario and its chapters work in partnership with a variety of groups. These include health service providers, primary care practitioners and clients. We have a long history of working together to improve access to services for our clients, promoting best practices in dementia care, and raising the profile of dementia-related issues.

So what is dementia? Dementia is a syndrome with symptoms that include loss of memory, loss of judgment and reasoning, and changes in mood, behaviour and communication abilities. These symptoms may affect a person's ability to function at work, in social relationships or in day-to-day activities.

Alzheimer's disease is the most common form of dementia. It's a progressive, degenerative neurological disease of the brain, and causes thinking and memory to become seriously impaired to a point where it is lost. Next to Alzheimer's disease, vascular dementia is the second-leading cause of dementia in the world.

I'll talk a moment about the prevalence and impact of dementia and Alzheimer's disease. At present, more than 180,000 people in Ontario have dementia, and in less than 25 years, this number will double. Within relatively few years, this will reach about half a million people.

Dementia is the leading cause of disability in Ontarians over the age of 60 years, causing them to live more years with disability than stroke, cardiovascular disease and all forms of cancer together. These are statistics from the World Health Organization, as recently as 2007. Most Ontarians with dementia today are supported outside of institutions. They're supported in their homes, with their families as caregivers.

Care partners of people with dementia report stress levels three times greater than those individuals caring for persons with other chronic diseases, and depression amongst these caregivers is nearly twice as common.

Dementia has a dramatic impact on the health care system as well. Persons with dementia use one third of all alternate-level-of-care bed days. Dementia is highly correlated with hip fractures, and persons with dementia occupy 60% of our long-term-care homes. Also, 57% of older persons presenting at emergency rooms have cognitive impairment and dementia. Today, in 2009, there is no cure for Alzheimer's disease and related dementias. Moreover, there is no effective treatment. Dementia is fatal.

Mr. David Harvey: I'd like to talk for a moment about the dementia-mental health interface. Progress in dementia care is tied to progress in mental health, in four areas in particular, the first being stigma. Persons with dementia face a double stigma: one associated with mental illness, the other associated with ageism. Often, older people feel excluded, diminished and marginal because of our fast-paced society. Add to this the experience of gradual cognitive decline and the accompanying self-doubt, and you have a potion that inhibits self-disclosure and leads to isolation. Unfortunately, our health system often reinforces these feelings.

Prevention is another area of connection to mental health. While age is the most significant risk factor, researchers think that the disease starts much earlier in our lives. A healthy lifestyle will reduce the risk for developing dementia.

A third area is in primary care. The strengthening of primary care is the key to adequate treatment of dementia, as it is in mental health. Differential diagnosis is central to dementia identification, as depression and delirium, among other conditions, can appear as dementia. The type of dementia also drives treatment responses. As well, in a family practice setting, the health of the care partner is monitored as closely as that of the person. In one study at the Trenton health centre, of the 15 people who were examined who appeared at the emergency department with dementia, eight of them were there because of issues related to caregiving, not because of issues related to the person with dementia themselves.

Specialized geriatric services is another area. A multi-skilled, flexible primary care service working in col-

laboration with specialized geriatric mental health offers a powerful team approach to supporting persons with dementia. In the late stages of the disease, responsive behaviours may emerge that can cause harm to the person or to others. Specialized geriatric mental health services provide added expertise and diagnosis, behavioural strategies and pharmacological treatment. As well, pre-existing serious mental illness can present exceptional challenges when combined with dementia. It's encouraging that in our audience today two of our partners in the southwest providing these services, at the Stratford hospital and London Health Sciences, St. Joseph's, are key partners in specialized geriatric services in our community here.

Dementia-specific supports are also provided by the Alzheimer Society, which offers a range of support services, including counselling and support groups. Counselling offers people the opportunity to understand and cope with dementia, plan for the future, discuss needs and issues and learn about community resources. Support groups offer an opportunity to meet, learn and share with others who are going through the same experience.

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There are confusing issues in the area of policy related to mental health and long-term care. Until persons with dementia are unequivocally identified as people who may benefit from the involvement of mental health practitioners, the struggle for adequate and well-planned supports for people with dementia will continue. Policy workers in government and planners in local health integration networks are cognizant of these policy issues but must wrestle with the history of indecisive policy within government that confuses all concerned. Initiatives to redesign mental health often overlook the potential partnerships of an enriched long-term-care system, and strategies to promote aging at home are inhibited by debates around whether or not the client should be served by long-term care or by mental health. We need to overcome that policy obstacle.

There are solutions and strategies that are in place, and we'd like to comment on a couple of these. Each of our chapters in Ontario has a public education coordinator who works in disseminating information about dementia to address the issue of stigma. As well, we are working in partnership with the Murray Alzheimer research program at the University of Waterloo to finalize an approach to age-friendly communities that will help communities become supportive of all persons with an impairment, but especially persons with a cognitive impairment. We recognize that it takes a whole village to support a vulnerable person.

As well, the risk reduction activities that are identified for dementia are the same as those for chronic diseases such as heart disease and diabetes. Dr. Rylett mentioned that vascular dementia is the second-leading cause of dementia. For this reason, the Alzheimer Society of Ontario is a partner with the Ontario Chronic Disease Prevention Alliance, which recently sponsored a symposium on mental health and health promotion.

There are some emerging opportunities in support services. Our First Link program, which began in Ottawa in 2002, has now expanded through the aging at home strategy to 25 communities across the province. At the moment, most of the GTA is not yet covered by the First Link program, but we hope that that will change in the next round of the aging at home strategy. First Link offers primary care practitioners the assurance that their efforts in diagnosing and treating Alzheimer's disease will be augmented by a direct referral to community agencies skilled in this area. Their patients will be provided with education, self-management tools, and will have an ongoing contact. Our commitment to a person who presents themselves to us at the First Link program is to keep in touch with them across the span of the disease.

Behavioural support services: I'm going to divert from the text here simply to say that in April, there were 70 organizations, including many LHINs, that met together to explore how behavioural support services can be developed in Ontario. We're meeting with the assistant deputy minister on June 25 to put forward some proposals. These proposals have been languishing—they're not new ideas—in this province for 10 years or more. In 2005, there was a coroner's inquest into a double homicide at a nursing home. Still, these proposals are not moving forward, primarily because of money. A recommendation from your committee could tilt the balance in this particular issue. I would urge you, as you move forward, to keep in mind the issues of dementia in the later stages of life in particular.

Dr. Jane Rylett: I'd like to advance to you a call to action. Your committee has an important role in urging our government, health care providers and our communities to action. We ask you to include, in your call to action, the following points: first, that Ontario's mental health policy and service framework include the needs of persons with dementia and their caregiving partners, especially at stages of diagnosis and early intervention, very early in the course of the disease when they're just learning about the disease and when responsive behaviours may emerge; second, that efforts to address the stigmas encompassing dementia and ageism be addressed; and third, that service capacity keeps pace with the growing numbers of persons with dementia and care partners throughout the continuum of the condition, which can span many years.

Mr. Chair and members of this committee, we need to work together to address dementia, consistent with our social values and traditions. The impact of dementia is immense and will only increase in the coming years as our society ages. If unprepared, we are at risk of being overwhelmed. If prepared, we are confident that our communities will be able to cope, Ontarians with dementia will live with dignity and their care partners will be supported. Thank you very much.

The Chair (Mr. Kevin Daniel Flynn): Thank you, David. Thank you, Shelly and Dr. Rylett.

We've probably got time for one question, so let's start with Sylvia, I think. Is it your turn?

Ms. Sylvia Jones: I actually don't have any questions. Thank you for your excellent presentation.

The Chair (Mr. Kevin Daniel Flynn): Oh, good. Okay. France, anything?

M^{me} France Gélinas: I just wanted to be clear that David—am I calling you by the right name? Yes. Mr. Harvey. You said a recommendation from us could help you. That was specifically to behavioural support services?

Mr. David Harvey: Yes.

M^{me} France Gélinas: Okay.

Mr. David Harvey: Or specialized geriatric mental health.

M^{me} France Gélinas: Okay, just expand a little bit as to what you would like us to do.

Mr. David Harvey: Oh, okay. There are services; geriatric psychiatrists, specialized neuropsychologists and nurses who are trained in providing support to people with responsive behaviours. Often these services are generally underfunded. They are sitting in the mental health sector; the clients are sitting in the long-term-care sector. There's always a resource debate between these sectors, and we would like to see a closer connection in those areas in particular.

M^{me} France Gélinas: Okay. This could be a clinical question, so if I'm out of order, just let me know. I'm certainly not very familiar with behavioural support services, but would some of those services and therapies have an impact as to the type of behaviour that developed as the disease progressed, or is it to teach people how to cope with the behaviour?

Mr. David Harvey: No, it would be to help with behaviours that are as a result of the progression of the disease. We already, through our chapters, do teaching toward caregivers. This is more of a clinical need.

M^{me} France Gélinas: So we could actually have an impact as to some of the behaviour not developing or developing differently?

Mr. David Harvey: That's correct.

M^{me} France Gélinas: Oh, okay.

Mr. David Harvey: If you've seen on TVOntario or the articles in the Toronto Star a few years ago, many of those issues are related to responsive behaviours and can be avoided if consulting services from the specialized geriatric field are available to long-term-care providers.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for your answers, and thank you very much for being here today. It is appreciated.

LONDON HEALTH SCIENCES CENTRE

ST. JOSEPH'S HEALTH CARE

The Chair (Mr. Kevin Daniel Flynn): Okay, if we can call forward now the London Health Sciences Centre and St. Joseph's Health Care. Make yourselves comfortable. It's good to see you again.

Like all the other presentations, you have 20 minutes. You can use that any way you see fit. If you could leave some time at the end, we'll be starting with this side for any questions this time.

Ms. Kristine Diaz: Well, thank you very much for giving us an opportunity to speak on behalf of the academic centres in the southwest: St. Joseph's Health Care and London Health Sciences Centre.

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The presentation you have before you will provide you with an overview of London Health Sciences Centre as the acute care mental health site, Regional Mental Health Care attached to St. Joseph's Health Care, and then move on into some further detail.

Dr. Beth Mitchell will start with the overview of London Health Sciences Centre. She is the director of the acute care mental health program.

Dr. Beth Mitchell: Good morning. I'll just give you a bit of an overview about London Health Sciences Centre. We are the schedule 1 hospital for London-Middlesex, and that's our primary area of focus. We provide acute care services across the lifespan, so from early childhood through geriatrics and everything in between.

The Chair (Mr. Kevin Daniel Flynn): I'm sorry. I should have asked each of you to identify yourselves as you speak. Everything's being taken in by Hansard, and they don't know when one voice changes to the next. So just the first time is fine, if you'll just introduce yourself.

Dr. Beth Mitchell: Sure. I'm Beth Mitchell.

Further to the kinds of services we provide, we have an emergency psychiatry team located in the Victoria Hospital emergency room 24-7. That's a team of nurses and psychiatrists that are available to provide assessment and consultation there. We have 68 in-patient beds for adults and 11 in-patient beds for children and adolescents, and that includes an eating disorders program that serves the region. We have ambulatory services, which include both general services and also specific services with early intervention, which I can speak to later, as well as trauma services and services for affective disorders. We offer consultation liaison services, which is a bit of a jargon word, but those are services where we provide consultation to the medical surgical units at London Health Sciences Centre—so those patients who have come in for medical reasons but also have psychiatric disorders.

To come into our service as an outpatient, we have a coordinated intake; that's one number to call and you can be triaged to whatever outpatient services you need, both at LHSC and some services at Regional Mental Health Care. We offer assessment and consultation, and in that consultation we do have an urgent service for adults as well as children, so that we can offer an appointment for a psychiatric consultation within 72 hours as an alternative to a visit to the emergency room, but also a more immediate service rather than a wait for a longer assessment. We provide crisis stabilization, both on an outpatient and in-patient basis, as well as ongoing acute treatment services.

We work closely with our partner at Regional, and I'm going to let Kristine provide the overview there.

Ms. Kristine Diaz: At Regional Mental Health Care, as you heard last evening when we met, we have two sites: one in London and one in St. Thomas. Our services are defined by mental health reform documents, such as *Making It Happen*, which identify the role for specialized mental health services. We work with those individuals who have the most severe and persistent serious mental illnesses and who aren't able to receive the level of care or services that they require in their home communities and their general hospitals. Currently, we have in-patient, ambulatory and outreach services serving the southwest—11 counties stretching north from Grey-Bruce, as far south as Elgin county, west to Essex and east to Waterloo-Wellington.

Our programs are built along diagnostic lines that include an assessment program; an adolescent program; dual diagnosis, which serves those individuals with a serious mental illness and a developmental delay; a mood and anxiety disorders program; concurrent disorders, which works with individuals who have a mental illness as well as an addictions issue; psychosis; geriatrics; and forensics. A key piece of our ambulatory services includes the 11 assertive community treatment teams that we sponsor through the southwest.

We currently are serving 441 in-patient beds and have approximately 3,500 registered outpatients across our various programs. So it's a large base of clientele that we currently work with.

Both organizations work in partnership with the University of Western Ontario to fulfill our academic and education mission. We continue to ensure that we use evidence-informed care as we plan for the care across our various programs at both sites, London Health Sciences and Regional Mental Health Care. We have a number of professionals from all disciplines who are involved in research and evaluation at all points of care, starting with our early intervention programs, moving right through to our geriatric programs, where I'm proud to say that we've been able to inform the field significantly in the last few years. We provide a huge role with respect to the education of all health care disciplines in an inter-professional team manner, and work in partnership with both the University of Western Ontario and Fanshawe College to fulfill that mandate.

You heard a little bit about the HSRC directives last evening. Just to highlight for you what those mean for us going forward, for London Health Sciences it meant the consolidation of acute care mental health at what is now the South Street campus in 1998. We will complete the final piece of those HSRC directives for London Health Sciences in 2011: opening a new mental health program at the Victoria campus on Commissioners, which will have 74 acute care adult beds and 16 child and adolescent beds. This will be the first time that both adult and child and adolescent mental health programs are on one campus, so we're very excited about that piece.

On Regional Mental Health Care, you heard about the tier 2 directives and the work we are continuing to do with that piece, which will mean that 55 beds will open in Grand River for specialized mental health care; 50 beds at Windsor Regional Hospital; 14 beds will be transferred to St. Joseph's Healthcare in Hamilton, and there will be a 15-bed acute care mental health unit at St. Thomas Elgin General, which will be opening sometime in the future. What that means for the southwest is a net loss of 67 beds.

We are also currently working with Infrastructure Ontario and the Ministry of Health to finalize our functional plan for Regional Mental Health Care, which will see us opening 156 beds in London; 89 beds in St. Thomas for forensics—and shelled-in space in London, to take us to 168—based on our population growth needs.

Dr. Beth Mitchell: Just to talk about some of the challenges and needs from the acute care perspective, I've broken these into three components: early intervention, ambulatory care development, and then strengthening community linkages.

In terms of early intervention, really we're talking about two types. One is during the lifespan, so trying to reach clients earlier, before they develop more chronic types of problems: working with children and adolescents, transitional-age youth, pre-geriatric or early geriatric clients so that we're trying to intervene, assess and set people on a course where they are able to recover and continue with more of a normal life ahead. This is also important in terms of the course of illness. It's very difficult, I think, in a system that's geared to look after people who have already been diagnosed and have already developed problems, sometimes of a long-term nature, to think about it in the same way we think about health promotion: think about early intervention, look for early signs. Early signs of psychosis—our early-intervention-in-psychosis program at LHSC has both a strong clinical record but also a very strong research record in terms of intervening with usually late teens/young adults who are presenting with signs of early psychosis, often schizophrenia and affective disorders, and intervening at that time. We've had up to an 80% success rate of return to school or return to job. Many of those clients are treated without ever coming into hospital, which is pretty amazing.

We also have begun a program in first-episode mood and anxiety disorders with the same intent: that young people, particularly who have never had an episode and are presenting with depression and anxiety, can be treated early, with the hope of avoiding a lifetime of more chronic kinds of problems. It's a dilemma in our system as to whether or not we support those clients who are already part of our system and obviously need care and treatment, but we also want to change the whole system in the way that we are providing people with a chance for recovery early on in their illness.

We hope to do most of that on an ambulatory care basis. We have a number of ambulatory care programs. Albeit small in number in terms of staff and physicians,

we serve probably 40,000 or 50,000 visits a year between all of our ambulatory programs. We're looking to partner more strongly with community agencies. We have a number of pilot projects with the Canadian Mental Health Association in London, as well as others, to look at how we partner and provide services through them or with them so that it doesn't mean a trip to hospital always; there are other ways of providing those kinds of services. We hope to grow and develop those as well with other health agencies, including long-term care and the CCAC.

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Ms. Kristine Diaz: For Regional Mental Health Care, our projected needs are somewhat different, given the patient population we serve. For both London and St. Thomas, we have a number of what we call legacy clients or patients who have been institutionalized for a number of years, and who, despite best efforts using the current interventions we have, including our assertive community treatment teams, will not be successful in the community given the risk, either to themselves or the community. The need for residential treatment facilities, we believe, is clear. Making It Happen does speak for facilities such as these to be linked to academic centres. Unfortunately, at this time, policy is silent on the development of residential treatment facilities in Ontario.

We would see the need for enhancing our outreach services as a projected need moving forward as community capacity is built. We've had some very significant success with our discharge liaison teams attached to the geriatrics program, as they support clients transitioning to long-term-care facilities, and using that model across the spectrum of care that we provide would be important. We feel we have a great need to link with our schedule 1 partners, which include London Health Sciences, in the development of an ambulatory service that is virtual in how we provide care, and that includes community partners like CMHA and other community agencies—the Alzheimer Society was one that you heard from earlier today.

The ability to link with the CCAC in a meaningful way that has some policy attached to it would be an issue that we would also support having some further dialogue on with the ministry and with your committee. The absence of actual directives for the CCAC to work with the seriously mentally ill means that there is some confusion around who works in collaboration in providing care for these clients, who have both physical as well as psychiatric needs.

Elgin county, specifically, is facing some challenges that we would like to bring to your attention. The delivery of acute care services within the St. Thomas-Elgin General Hospital will be a new avenue for this institution. There will be requirements that will need to be made at the Legislature with respect to the Mental Health Act around enhancing that role for Elgin General, as well as new learning for all areas within that organization in providing acute care mental health ser-

vices. We are working in collaboration with Elgin General as they start their functional planning process.

The economic downturn in the southwest is obvious to all, and we are starting to feel those effects across both community service providers and the hospitals with respect to the increased stress that families are under and the diminishment of privatized EAPs as they relate to employment and employers. As unemployment rises, we have individuals who now have no safety net with respect to those resources.

I would echo the challenges that many of our community partners have echoed—and that various planning documents such as the South West implementation task force document identified—around regional resource disparity. There are areas and pockets within the southwest that have limited resources and access to specialized psychiatric services such as psychiatrists, specifically, trained into professional teams. The need to continue to have and request for investment in housing, long-term care and treatment in the community is essential.

In conclusion, we would advocate that your committee work strongly with key stakeholders and the Ministry of Health in looking at how we can determine the needs of this population across a variety of ministries as well as ensuring that there is investment in the community. That investment in mental health and the community will allow the most expensive resource, the hospitals, to do our work effectively and efficiently.

I'll turn the table over to Dr. Sandra Fisman, the chair/chief for UWO and LHSC Regional Mental Health Care.

Dr. Sandra Fisman: I'm here as somewhat of a resource, to answer any questions. I'm the chair of the department of psychiatry at the Schulich School and the chief of the mental hospital services, which would be St. Joe's and LHSC. I'd like to just briefly comment on some of the things that I heard sitting in the audience, if that's permissible.

One of the very passionate comments about addictions and mental health really resonated for me, and I think an important area that we're finding is amongst youth often presenting with a mood disorder or with an anxiety disorder and concurrent use of substances, with very little in the way of resources to manage the addiction component. I think Beth was mentioning that in our early-intervention mood and anxiety disorder program, which is sort of built on a shoestring or less, we've finally been able to cobble together, through a special opportunity fund, a day a week of an addiction counsellor to work in that program. But I couldn't agree more with the comments that these are undiagnosed, the comorbid addiction problems, and absolutely need to be addressed. Perhaps this is an opportunity to drive the message home.

The other important piece that I heard was the link between geriatric psychiatry and geriatric medicine in long-term-care facilities as I listened to the Alzheimer presentation. I think the consultation/liaison team that Kristine described, which provides support to people being discharged from Regional Mental Health Care,

geriatric psychiatry, into long-term care, and being able to access back readily is something that is a model that we should look at, not only in tertiary care but on the acute care side as well.

One of our perhaps large gobblers of emergency services in mental health and in medicine is people who can't be managed in long-term-care facilities, and it becomes the path of least resistance to simply bring these people to the emergency room and to leave them. I think that if we could develop a similar system on the acute care side, we'd be able to prevent those emergency room visits and maintain people in long-term-care facilities with those behavioural interventions that the previous group were describing. We're not able to do that because we are unfunded on the acute care side to do that. I don't know whether Beth wants to add anything to that—

Dr. Beth Mitchell: Yes, we are.

Dr. Sandra Fisman: —but we really see a great need for that.

Finally, in terms of the role for the academic hospitals, we see ourselves as very much needing to be sort of at the hub, developing effective models of care, doing the research, educating and training people to practise in the community and of course the whole southwest, and wanting to be part of a continuum of care, but as I think Kristine was saying, really supporting that community services be developed so that there's not a total reliance on hospital services.

The Chair (Mr. Kevin Daniel Flynn): Thank you.

We probably have time for one very short question and one very short answer. Liz?

Mrs. Liz Sandals: Kristine, you mentioned that policy was needed for residential treatment facilities. I just want to make sure I understand what you mean. What I think you mean would be the equivalent on the medical side to complex and continuing care, that you've got someone with a chronic condition and you need residential facilities for people with chronic mental health. Is that what you're saying?

Ms. Kristine Diaz: Residential treatment facilities are a model of care which in other jurisdictions, in other provinces, fall under their mental health act with respect to ability to have someone under a mental health certificate in those facilities, to have them secure. So that's the piece.

It really speaks to some policy around two things: one, some reform of the Mental Health Act; two, a shift or an opening of policy around what services would be available outside an acute care setting for individuals such as this.

Mrs. Liz Sandals: But it could in fact be fairly secure, sort of what I would think of as closed custody when you're doing youth corrections.

Ms. Kristine Diaz: Exactly.

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The Chair (Mr. Kevin Daniel Flynn): Thank you very much for your answer, and thanks for coming today.

CAMH CENTRE FOR PREVENTION SCIENCE

The Chair (Mr. Kevin Daniel Flynn): If we can move on to the CAMH Centre for Prevention Science, is Dr. Claire Crooks in the audience?

Dr. Claire Crooks: Yes, right here.

The Chair (Mr. Kevin Daniel Flynn): Oh, how are you doing? Okay. Would you like us to go on to the next one or are you all set to go?

Interjection.

The Chair (Mr. Kevin Daniel Flynn): No, no, that's fine. If it's only going to take a second, then we can wait. Welcome.

Dr. Claire Crooks: Are you ready?

The Chair (Mr. Kevin Daniel Flynn): We're ready. Like everybody else, you've got 20 minutes. You can use that any way you see fit. If there is any time at the end for any questions and answers, it's always best, but it's not absolutely necessary. The floor is yours.

Dr. Claire Crooks: Good morning. Thank you very much for the opportunity to present today, along with my colleague Charlene Camillo. We're going to talk today about meeting the unique needs of aboriginal youth and making a case for strength-based programming and explaining what that means.

I'm Claire Crooks. I'm a clinical psychologist and the associate director of the CAMH Centre for Prevention Science in London. For the last 10 years, I've been working with my colleagues David Wolfe, Ray Hughes and Peter Jaffe on violence prevention programming and other related risk behaviours through a program called the Fourth R.

About five years ago, I started to work more specifically with aboriginal youth, trying to understand how our programs needed to be a bit different or why they seem to be missing or not accessed the same way and with the same effect for aboriginal youth as for their non-aboriginal peers. What I want to talk about today is how our thinking has emerged about what aboriginal youth really need to develop the skills, mental health and competencies that are going to make them successful citizens.

I'm going to give you a really brief snapshot of aboriginal youth—and I don't want to belabour this because I trust, as the Select Committee on Mental Health and Addictions, that you're familiar with these numbers. The overall view is that aboriginal youth, families and communities experience almost every negative health outcome at a disproportionate rate compared to other Canadians. When you look at individual adjustment, you see higher rates of alcohol and other drug-related problems, unemployment, suicide, depression and other risk behaviours. That doesn't come as a surprise. You can pick up the newspaper and see that.

Similarly, high school achievement and academic achievement is disproportionately low. The last time I saw these numbers calculated—one way to think about it is that aboriginal youth in Canada actually have a higher

likelihood of being incarcerated than they do of graduating from high school. That's a really important thing to wrap your head around because it says a lot about what the norms are for a particular group. What it means when you do choose and become successful in graduating from high school is that you've actually gone against what's happening with the majority of your peers.

Once aboriginal youth do graduate, interestingly, they tend to proceed to post-secondary education at equivalent rates to their non-aboriginal peers, even though there are some differences between college and university in terms of where they go.

When you look at families, you see similar rates of problems: Stats Canada data would suggest five times the rate of family violence and a disproportionate number of kids in foster care.

At the community level, it's interesting, because we know that suicide rates are higher, but there has been some really important work done out in British Columbia looking at the range across communities. What these researchers, Chandler and Lalonde, found is that when you look across all the different reserves in BC, there's a range from communities that haven't had a single suicide in five years to communities that have 800 times the national average. That's a really important thing to think about, because if you can understand a little about what's different in those communities, that's a really important lesson for us and an opportunity moving forward. What's different about those communities is the context in terms of the extent to which aboriginal communities have regained a sense of cultural identity, autonomy and self-governance. I'm going to explain a little bit about why that's important.

Those are just numbers. They really don't tell the story. Those are the numbers that are easy for people to throw around or easy for the media to throw around, but they really don't paint a picture of why. I think all too often we accept those numbers around suicide and substance abuse without stepping back and thinking, "How does this make sense? Why is there an identifiable group of youth and adults in this country who experience such disproportionate outcomes? Is it something inherent about them being aboriginal?" Because if we accept that, that's a very negative and biased kind of hypothesis. You need to look beyond that. I would argue, and a lot of people have argued, that what we need to look at is the context, and by that I mean looking a little bit at the history and the contact between aboriginal and non-aboriginal peoples in Canada.

I'm going to talk specifically about residential schools for a few minutes and why it matters. It's important to remember that residential schools are just one symptom of the whole colonization process, but in some ways it's the easiest for us to understand. I think there has been a lot of understanding developing around residential schools, in part because of the leadership of the federal government in putting together an apology just over a year ago, but there are still a lot of myths and misconceptions. Even people who understand residential schools

still kind of have this, "Why does it matter now and why isn't it something that people can just get over? A lot of these people who have trouble didn't even attend or their families didn't attend." Trying to understand that link is still a challenge.

I've identified some myths that I tend to run into doing training about residential schools. I just want to debunk each of these really briefly and then move on to what we're proposing as a solution.

The first myth is that residential schools were benevolent boarding schools or that they were somehow about education. That's a really easy one to debunk because you just have to go to the federal government record itself. What becomes clear is that residential schools were part of an aggressive assimilation policy. It's not cloaked in anything more subtle than that. The idea was to solve the Indian problem, take the Indian out of the children or to kill them trying, and either outcome would have suited some of the policy-makers of the time. Really, very little education attainment occurred in general. Obviously, there's a range, and there are adults who speak positively about their experience, but they're in a great minority.

The second thing which I think there's been a little bit more visibility about is that people still associate residential schools with the churches—the Catholic Church, the Anglican Church, the United Church. Although all the churches were partners, this again was a federal government strategy. It was funded by the federal government and subcontracted out. Sometimes people are confused about how long residential schools lasted or when they ended. The reality is that they lasted in some form or other for over 150 years, which is generation after generation of being taken away from your family and community at a very young age and being punished for speaking your language or acknowledging any siblings or cousins or kin. The last one closed in Saskatchewan in 1996, so they're a very, very recent part of our history.

The last myth, which is a little more complicated to understand, is this idea that when we think of residential schools now, we immediately think of all these reported cases of physical and sexual abuse. Obviously, those are terrible things for children to experience, but sometimes people take the next step and think, "If they didn't actually experience that, then it probably wasn't so bad." The reality is that there's a cultural or spiritual abuse that is there even if you weren't physically or sexually abused or neglected. That cultural or spiritual abuse is really what we talk about as the legacy or the intergenerational trauma that we see. You have these children who get removed from their homes for up to 10 years and are often shuttled across the province, so they're not put into a residential school close to home because then there's a chance they can run away and still connect with their families. They're punished for speaking their language—everything that makes them who they are is stripped away from them, so it's very different from a traveller in a foreign land where you don't speak the language but

you're aware that you're there by choice and you're going to go home. It's being ripped out of everything that makes you who you are and being told that that's somehow shameful or dirty or subhuman and that these people are going to save you by making you something other than what you are.

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When you come home, you don't fit in there either. So now you have these kids—and this is generation after generation—who come home and now don't really fit in either world. They still don't have the legal rights of a Canadian citizen off the reserve, but they come home and don't speak the language, don't know the traditions. You have these children then becoming parents, having had no model of parenting, so replicating what they've learned about abuse and power in residential schools. Again, over the generations it actually has accelerated, so we see higher rates of problems now, further away from the residential schools, than were initially witnessed.

There is low education and career attainment, poverty, high rates of substance use and interpersonal violence and a big mistrust of the school system, which is, again, not surprising. I have a quote here from a young woman who lives on Chippewa, and I just love the way she put this. She said, "It's where our parents are coming from. It's where our grandparents are coming from. By the time you get to my generation, we have all the baggage and we don't know where it comes from."

I think that's a really important piece too, that just as the average Canadian doesn't have this context, the average aboriginal youth doesn't either. They don't think, "Well, I look around and my friends are sniffing inhalants and dropping out of school, but hey, I'm part of a post-colonial history and we need to overcome this." It's just this internalizing of somehow not being as good as or as successful as non-aboriginal youth.

So if that's the history and the backdrop, I think where we are right now, there are reasons to be hopeful and there are reasons to be disheartened. Looking at the education system specifically, because that's where I do most of my work, there are some really promising things being set forward and some real leadership by the government, looking at policy directives. There's a new Aboriginal Education Office, and they have this directive about incorporating aboriginal perspectives, closing the gap in achievement, raising confidence—lots of funding. So that's a really positive framework, and I think this committee has the same opportunity to sort of set that framework. The reality is that there's a huge capacity issue and a really long way to go in terms of what that actually means in day-to-day practice.

I'm just going to give you an example: something I saw in December that really, to me, speaks to the acceptability of discrimination that's still here, even though Canadians hate to think of themselves being discriminatory. The Ontario College of Teachers is the official regulating body of teachers. If you have a complaint against a teacher, that's who you complain to. They have an adjudication process. I'm just going to show you a

complaint that was written up in their December journal, because I think the complaint and the college's response are very informative.

So the complaint is: "A parent complained to the college about a grade 3 teacher's alleged racist comments, made to the class during a unit on aboriginal Canadians, as reported to the parent by the parent's child. According to the student, the teacher stated that aboriginal Canadians begin smoking at age 8, sit around drinking alcohol all day, don't work and permit their children to 'run around wild' until late at night." So that's the report; the child comes home and says, "Hey, this is what my teacher said." The parent is concerned and writes in. Obviously that's very troubling, but you don't let one teacher spoil the bunch for the whole group.

What's more concerning to me is the college's response, which is this: "After a full investigation, the investigation committee panel reviewing the complaint sent a written caution to the member to be cognizant of the age and level of the students being addressed when dealing with sensitive subject matter." So the way it's framed is that it's the wrong age. You don't tell kids the real truth about aboriginal Canadians at grade 3; they're too young then. You know, wait until grade 9 or 10.

What I would submit to you is that if you put any other identifiable group in there for aboriginal Canadians—if you put Jewish Canadians, Muslim Canadians, homosexual Canadians—there would be such an uproar and yet this is such a part of our post-colonial history that I think people would read it and think, "Oh, that sounds like kind of a crummy teacher." But even the institutional response is really disappointing, in my mind.

So that's the history. We get to this point, then, of: What do aboriginal youth actually need to be successful? This is a question we've spent quite a bit of time researching, both with youth themselves—we've done a number of videos and projects looking at that—and looking at other people's research. Really, what you need are intentional engagement strategies. Within most institutions, be it community programming, be it schools they don't feel like they fit in. They don't see themselves reflected there. They need intentional engagement strategies to be made to feel that they belong in these institutions. They need an environment that feels comfortable and welcoming and educators who connect with them at a personal level. They need access to role models with whom they can relate, educators who understand their realities and set high standards for them. This is something youth tell us again and again: "We want teachers, we want social workers, who understand where we're coming from, who've been out to the reserve, who know what my life looks like but don't lower their standards for me because of that." They don't want the message, "Well that's pretty good work for a native kid." That's what they feel they often get. Parents have told us that too. They'll call in and say, "My child got 79% on a test. What can we do to improve that?" And the teacher will say, "Well, 79% is pretty good," and there's that unspoken "for an aboriginal kid from the reserve."

Finally, they really need an opportunity to develop and use leadership skills. No individual always wants to feel like they're on the receiving end of a program. They don't want to feel that they always need the help. They want a chance, like every person needs, to be part of something positive and something where they're part of the leadership for change.

Over the last four years, along with a couple of colleagues, we've developed a tool kit that looks at principles, strategies and case studies for effective programming with aboriginal youth. I brought one copy of it for the committee.

What we did is we organized our thinking around some guiding principles: that effective programs, first of all, understand and integrate cultural identity; they increase youth engagement; they foster youth empowerment; and they develop and maintain effective partnerships with community partners and family. I'm just going to talk about the first three, and then Charlene's going to talk specifically, as an example, about a peer mentoring program that we've developed and have been running.

The first principle, and it should flow logically from where I started with this, is that if loss of cultural identity or theft of cultural identity, if you will, is a major risk factor at both the individual and community level, then really we need to rebuild and give opportunities for communities to rebuild what's been taken away. That's a very different picture than saying, "There's something about aboriginal Canadians that makes them use drugs at higher rates." That's saying that there's this process, this place in time where we are now, historically, where something that was taken away needs to be rebuilt. The communities themselves have the best ideas about how to do that, but there are lots of ways that we can be good partners and support them.

Therefore, connecting youth to culture and teaching non-aboriginal students and adults about the culture and contribution of aboriginal peoples should be an underlying goal of virtually all programming. That's the thing that, again, I think the Ministry of Education really got right. It's not just about having better programming for aboriginal youth, it's also about all Canadians learning about the contributions of aboriginal people so that they're not always seen as the problem or a public health concern. But I would submit that the average educator or service provider has no clue how to do this, even when they want to. So you can go and learn about residential schools, as a teacher or a community worker, and think, "All right. I need to do something." But without really clear guidance and structures and resources, sometimes you can make things worse because you try to do something that ends up being very tokenistic or that somehow still misses the mark.

Again, if you look at this historical context, you realize there are lots of reasons for low engagement: previous experiences, the fact that they don't see themselves reflected in the school or in community programs, the logistics of getting to school or other programs, low academic attainment starting high school—we've done a

lot of work looking at the transition from elementary to high school, so there are all kinds of other problems by that point. If you're already behind in reading, in math, it's hard to then transition into a large, inner-city school and feel successful. So, really, we need to develop specific intentional strategies.

Finally, this idea of fostering youth empowerment, which is that all youth need to develop skills and need to be able to use them for change: Especially with marginalized youth, the opportunity to be a leader and to be a positive influence in your school and in your community can really be a life-changing and transformative experience. When we talk about our experience with the peer mentoring, we've seen that very clearly in a number of cases. But these leadership opportunities need to be built into the structure of schools and programs because, again, these kids don't just self-identify. So you can have a great student action committee at a school or youth centre, and you can put up a flyer that says, "If you're interested in being a youth leader on this committee, come on out." In general, the aboriginal youth are not going to be the ones who come out and self-identify that way, so that's where you need the engagement strategies and you need to think about the skill-building and empowerment.

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At this point I'm going to turn it over to my colleague, who's going to hopefully—

The Chair (Mr. Kevin Daniel Flynn): It's going to have to be a really brief hand-off. Are you good at summarizing, Charlene?

Ms. Charlene Camillo: Sure.

Dr. Claire Crooks: What time are we—

The Chair (Mr. Kevin Daniel Flynn): You've got maybe two minutes left.

Dr. Claire Crooks: Okay, shoot.

The Chair (Mr. Kevin Daniel Flynn): That's okay. No problem. And I don't want to dismiss the importance of the end of your presentation; I'm just trying to be fair to everyone who's sort of confined themselves to the time limit. If you could go through it fairly quickly and then maybe summarize at the end, that would be great.

Ms. Charlene Camillo: Sure. For about the past four years now, we've run a peer mentoring program for aboriginal students in three of the schools in Thames Valley. We feel that a mentoring program fits well culturally with aboriginal people, because in most communities, it's not just the parents' job to raise children; it's the whole community's: aunts and uncles—it's really a whole family and community bringing up the children together.

In our program, for the peer mentoring, there's a lot of emphasis on oral traditions that we use. We use sharing circles, and it's the youth together. It's a chance for them to have a leadership role and mentor a younger First Nations student.

Who's involved? We have mentors who are selected as good role models in their schools, who are attending their classes and putting forth all their efforts. We have

mentees who are younger aboriginal students, usually in grade 9, where it's been identified that it would be helpful to have an older student there to help guide them, someone they can turn to and talk to. The First Nations counsellors at each of these schools are very involved in the programs of helping us select the students and organizing the date and time that the students are going to meet. We also have a community mentor who's selected through a process of referral from the community, and First Nations counsellors might recommend them to come in and speak to the students.

We'll just go on to the manual and training—

Dr. Claire Crooks: The successes.

Ms. Charlene Camillo: All the successes; okay.

Just a quick breakdown: Each semester, the students would meet for lunch once a week. The successes of the program: We have shown that involvement in this program increases engagement of the students in their own school and in other clubs and programs in their school.

The program has grown each year, and there's been a change in the referral patterns, so it's not just the First Nations counsellor identifying now; students are seeing their friends being involved, and they're more willing to become involved in this program. There's a huge retention, and the number of youth who are moving from mentee to mentor increases each year. It's often a goal of the mentees to stick with the program. They enjoy it and see it as a goal for them to become a mentor to other students.

There have been many youth who have graduated who have been involved in our programs and have continued with their education and career opportunities, and we have many great individual stories that we obtain from the program—success stories of students becoming more involved in their school and how this program itself was the stepping stone for that.

The Chair (Mr. Kevin Daniel Flynn): Wonderful. Thank you very much for your presentation.

Dr. Claire Crooks: We have other materials about the specific programs that I can send in, if that would be helpful.

The Chair (Mr. Kevin Daniel Flynn): If you would send it in to the committee, that would be great.

I noticed your background, Charlene. The committee, before you arrived today, agreed to visit a certain amount of First Nations communities. One of those was Moose Factory, I think—Moosonee. Maybe you can give us a little bit of advice as to what we might expect and maybe what we should see up there as well.

Ms. Charlene Camillo: When are you heading out?

The Chair (Mr. Kevin Daniel Flynn): August.

Ms. Charlene Camillo: August: I might be up there.

The Chair (Mr. Kevin Daniel Flynn): There we go. Maybe you can meet us up there; we can spend a little bit of time.

Ms. Charlene Camillo: Yes. When in August?

The Chair (Mr. Kevin Daniel Flynn): We'll be in Moosonee on the 26th and 27th.

Ms. Charlene Camillo: If you're there for the long weekend in August, they have an annual gathering, so I'll be there. I'm playing in a basketball tournament and helping to run a basketball camp for youth. But later on, there'll definitely be blackflies. It'll probably be a little chillier than usual.

To get to Moose Factory, you'll have to take a boat taxi across to the island. Be sure to walk around: There are a lot of historical sites. Say hi to quite a few people because I'm probably related to about half of them.

The Chair (Mr. Kevin Daniel Flynn): We will do that, and thank you very much for coming today. That was a great presentation.

Ms. Charlene Camillo: Thank you.

HURON PERTH HEALTHCARE ALLIANCE

The Chair (Mr. Kevin Daniel Flynn): Our last presenters before lunch are from the Huron Perth Healthcare Alliance. Andrew Williams, Penny Cardno and Terri Sparling, if you would like to come forward and make yourselves comfortable.

For the other members as well, this afternoon, we're having ASL interpreters from the Canadian Hearing Society, and they've asked that as we speak and as the presentations are made, people be very, very clear and precise in their comments and identify themselves. We'll go over that again after the recess at lunch, but if you would like to identify yourselves as you present so that Hansard knows who's talking at what time, that would be great. Like all other presentations, you have 20 minutes. Use that any way you like, and if there's any time at the end, I'm sure we'll have questions for you.

Mr. Andrew Williams: Thank you very much, Mr. Chair, committee members and guests. It's a pleasure to be here this morning. My name is Andrew Williams. I'm the chief executive officer of the Huron Perth Healthcare Alliance. We are here today to discuss a gap in our local mental health system, specifically as it relates to children and youth and their access to acute care beds.

It has been really interesting sitting and listening to the stories this morning, some very personal, some at the system level, but I think they all boil down to the fact that we have cracks in the system, and that's where we get into trouble. So what we are really here to talk about is a crack in our Huron-Perth health care system that we feel needs to be fixed.

I'm going to pass it over to my colleagues, who will introduce themselves and take you through our presentation. I do expect we'll have some time for questions. We're not going to take the full 20 minutes in our talk, but hopefully there'll be some good opportunity for dialogue at the end of it.

Ms. Terri Sparling: My name is Terri Sparling, and I'm the chief executive officer of the Huron-Perth Centre. We're a children's mental health centre that is funded by the Ministry of Children and Youth Services, and we're accredited through Children's Mental Health Ontario.

Ms. Penny Cardno: My name is Penny Cardno and I'm the program director for mental health services with the Huron Perth Healthcare Alliance. Good morning.

We understand that the Select Committee on Mental Health and Addictions has been mandated to examine access-to-care issues for persons with mental health and addiction issues, including primary care and emergency care. As representatives of Huron and Perth counties, we thank you for giving us the opportunity to present the gap on lack of access to acute care mental health beds for children and youth in Huron and Perth counties and the impact that this has on the children and their families, to present our collaborative efforts to respond to the gap in Huron and Perth, and to present a more permanent response for seriously mentally ill children and youth in Huron and Perth counties.

To help you understand the significance of this issue, I've presented a case scenario. This involves a young man who's eight years old who presented to one of our emergency departments in Huron county. He was brought to the emergency department by his mom and his stepdad, and the family had identified that this young man was becoming increasingly aggressive at home. A situation involved him being brought to the emergency department one evening after his mother reported that he'd become more aggressive with the three other children in the home. Johnny, which is what I'm going to call him, has a history of sexual abuse as well.

On this evening that he presented to the emergency department, the family indicated that he took a knife from the kitchen and stabbed a pillow repeatedly. When the emergency department physician saw him and questioned him, Johnny referenced the fact that he was hearing voices and that the voice actually told him to cut off the head of his sister's doll. The emergency room physician spoke to him further and Johnny alluded to the fact that there was a horse and buggy outside of the emergency department that were waiting for him to run away. There was no horse and buggy outside the emergency department.

The emergency room physician really felt that admission to an acute care institution was the most appropriate, given the severity of his symptoms, but in Huron and Perth we have no access to any acute care beds for children and youth. So the process that we have established in Huron and Perth is one where, in partnership with children's mental health services, the Huron-Perth crisis intervention program links with the Huron-Perth Centre for children and youth and a request for an emergency consultation is arranged.

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Some statistics that we have are that last year in Huron and Perth counties, 400 children required admission to an acute care bed that wasn't provided. We have no access to any acute care beds in this province, and, as a result, we've worked very hard, together with our community partners, to come up with an alternative method of managing these situations.

Ms. Terri Sparling: Before I talk about the efforts that we've made over the last 10 years to try and resolve this issue, I'd like to put a bit of provincial context.

It's important to recognize that, historically, children's mental health has been underfunded across the province. There was a 12-year period of time where, provincially, there was no increase in base funding to manage increased costs; in fact, there was a reduction in that period. I mention that because prior to 1999, we as a centre would have actually just sent families to hospital thinking that the hospital would respond and having no idea what would happen after that. We would have said we were not positioned to provide a crisis response. However, in 1999 we received initially \$45,000 to create a 24-7 crisis response, and it was recognized that \$45,000, even at that time, was not going to be able to create a 24-7, 365-day-a-year service, so we partnered with the Huron-Perth crisis intervention program. They're funded by the adult system to provide crisis response and, on courtesy, they provide the front door to our service. We use our limited funding to actually allow us to pick up cases in a priority way. Again, \$45,000 in 1999 was not a lot. We've had it increased so it's now about \$80,000. But in total that's how the system works.

We have no after-hours capacity, so I carry a cell-phone on courtesy to my community partner, because we have access to psychiatric consultation, again, through the Ministry of Children and Youth Services, but the only way I can offer that to my partner is through me. So after hours they link to me if they need a psychiatrist and that's how I would have a child seen. That's just a little bit of context.

Specifically, then, in Huron and Perth we have two significant gaps that impact on our most seriously ill children, and frankly impact on our entire system. We have no access to acute care beds—we've mentioned that—and we have really no ongoing child psychiatry, with the exception of this emergency psychiatric consultation service, and in the last two years they've added telepsychiatry. So we have no child psychiatrist practising in our community.

The impact and burden this places on local hospitals, family physicians and community-based services and on families is enormous. The services that get drawn in to support families in crisis—really, that becomes at the expense of families who may be waiting for service but are not presenting in those more urgent states. Our current system, as I mentioned, has been created, really, in collaboration, and I describe it as a bit of a courtesy service. On courtesy, the Huron-Perth crisis intervention program, with no money from health, provides our front-door response, and, on courtesy, we respond after-hours to link them to limited things. At the end of the day, though, if a child needs to be hospitalized, we have no ability to hospitalize. We have to create safety with those family members; we have to draw in additional supports. Oftentimes we're sending families home with a little bit of medication through emerg doctors just to get through the night, and then our services are being required

importantly to manage cases that really would be more appropriately managed in an acute care situation.

I am aware that since 1999 and the Health Services Restructuring Commission—that's when we were formally designated as outside the catchment of London, and therefore formally without access to acute care beds for kids under 16. The gap has been identified. Through various health structures we have worked to identify the gap and bring resolution over the last 10 years, and that fact sheet in your package outlines our efforts since 1999 to have this issue addressed. We've worked with the district health councils, the Ministry of Health, more locally with the southwest LHINs, and my own ministry, the Ministry of Children and Youth Services.

I think it's important to know that in this province there are only four counties that have no formal access to acute care, and that would include ourselves—Huron-Perth—and Bruce-Grey. What that means is that every time there is a child who presents at an agency, in a school or, ultimately, at the emergency department in our two-county area and that child is deemed to be in need of acute care treatment, we really have two crises: We have the crisis of the child and how we are going to respond, and we have a systems crisis.

The kind of pressure that this gap places on our community is enormous. I've mentioned that the Huron-Perth crisis intervention program continues to respond without any funding in order to develop a plan to support that child and family until our agency can pick them up the next day. When we pick up those cases the next day, that will usually mean that a family on the waiting list will wait longer. It puts pressure on emergency departments, which continue to be required to see these children without having access to a child psychiatrist on-site, having to link into our service, which then offers them access to a psychiatrist in London, which means we then have to transport the child who is in crisis to London to be seen, and if that child needs to be hospitalized, we're stuck.

Family doctors see these children and youth in their practices all the time, with the same lack of real local options when acute care may be needed. Our service, as the children's mental health centre, attempts to manage those situations, the child and their needs and their family, and that means that these cases take priority over the other, non-urgent cases. Currently I have 256 children on the waiting list for outpatient service. Just because there are more clients—families identified in need of service—doesn't change the funding level.

The Huron-Perth centre, as an outpatient service with day and evening hours only, gets placed in a role 24-7 to link local hospitals to our emergency psychiatric consultation service, and that's the only real way we ever have access to acute care from regional resources. Fortunately, we've had a positive relationship with the Children's Hospital of Western Ontario, specifically the in-patient unit. It's those psychiatrists who also work on this emergency psychiatric consultation service who, if they have space, sometimes find us a bed. But we never have

any sense at the time of a call that we have access to a bed, and I can't tell you the number of times that my staff have needed to provide more intensive services to families just to get them through the period of crisis. There was one case where we actually had the child report to our outpatient service three days in a row in order to allow her mother, a single mom, to continue to work, because she didn't have enough of a social net to actually step up and provide supervision to a child who would not agree to stop hurting herself.

Mr. Andrew Williams: To be candid with the committee, I think you would all agree that we haven't given the attention to mental health and addictions that we should have. It's very comforting to us to see your efforts, and we're very confident that they are going to truly elevate. I've worked in health care for about 22 years, and I've really never seen this important area get the attention that it does deserve.

We have a very visible and public health care system and are making a lot of efforts to improve it. I think health care is front of mind with a lot of people, whether it's addressing emergency department waits, reducing hip and knee surgery wait times, access to MRI—you can go down the list. What we haven't yet done, though, is prioritized adolescent and mental health care in this province to the degree that it should be.

In our particular situation, and it's been alluded to already, we are one of only four counties—geographically, in case you're not aware, Perth and Huron counties are directly above London-Middlesex. So St. Marys is one of the southern towns in our region, and Goderich would be one of the northern towns. We're very close to London. But we are two of only four counties in the entire province that have no access to adolescent beds for our youth. It's a huge gap in the system. I cannot think of—and I've tried to—another single service where I could say there's no access. We may not have an MRI in Huron-Perth, but our patients can get on the waiting list and can get seen. Our children and youth who need to be admitted to a bed can't be, and it really is a challenge for us.

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The need for beds specific for children and youth—it's been an acknowledged need for over 10 years. The Health Services Restructuring Commission was mentioned. For those of you who may remember that group, it came through urban centres with a lot of vim and vigour, made a lot of pronouncements and a lot of investment recommendations, including mental health, and then came to rural Ontario and was basically silent. So we had the recommendation in London-Middlesex that they should focus on only London-Middlesex for child and adolescent mental health bed needs. They came to our area and made no follow-up recommendation that said we should have beds in our region as well. So we have been advocating, over the last 10 years, to try and get those beds to fill that need.

Now, we have cobbled together local solutions by working in partnership with our community providers,

and I commend Terri and her leadership to work closely with Penny and our team. We have a fantastic team on the ground, really trying to provide safe solutions for our children. But trust me: It's not adequate. As you've heard through the sessions today, where we run into trouble is when people fall through the cracks, and our children and youth are.

We're not here today asking the committee to consider a new program. We're not here asking the committee to deal with a major system issue. We're really asking you to advocate on behalf of the children and youth who live in Huron and Perth—and in Grey-Bruce, because those are the other two counties that don't have these beds—for equitable access to beds when they need it. Because if we're not looking after our children in a timely fashion, then we are creating not only problems in the moment, but we're certainly undermining their future and a large part of our society's future.

So our request today is simply that you put this on the agenda; that you join us in advocating for what we think is a very serious gap for the children and youth of Huron and Perth counties.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Andrew, Penny and Terri. You have left some time for some questions. We're going to start with Sylvia and then get around.

Ms. Sylvia Jones: Thank you. So based on your location, would I be correct in assuming that the beds that you would like to see for youth and adolescents would be based out of London?

Mr. Andrew Williams: No. We have a schedule 1 mental health facility at our Stratford hospital, and the proposal that we have in front of the LHIN and the ministry is to locate a unit in Stratford.

Ms. Sylvia Jones: Those are only—is that four beds, did I read that?

Mr. Andrew Williams: Three beds. There were two proposals put in: one in Owen Sound for Grey-Bruce and one in Stratford for Huron-Perth. All of the providers, hospitals and communities support the locations where they are, so we're hoping to locate it with our existing mental health services at our Stratford hospital.

Ms. Terri Sparling: Sorry, I would just add that certainly the best solution for families is closest to home, but if in fact that wasn't possible, we're asking for access.

Ms. Sylvia Jones: So today, when you are looking for that acute bed, what are you doing? You're calling around?

Ms. Terri Sparling: No. First of all, we're assessing at the local level, and we're putting together whatever resources happen to be available in that moment, depending on the time of day. If we can stabilize the situation, we'll do that; if by picking up the case immediately, we'll do that. If the child needs to be seen by a child psychiatrist, I call London. I queue up a psychiatrist, and they confirm a time for the child to be seen. We try and problem-solve how we're going to get the child safely to London, whether that's family,

emergency, my staff, whatever. The child is seen, and I still don't have any sense that I'm going to have access to a bed, but I go to the next step, which is at least to have the child seen by a psychiatrist. And it's been that psychiatrist's connections, where, from time to time, they've pulled strings and had a child hospitalized in London, but otherwise they're sent home with meds.

The Chair (Mr. Kevin Daniel Flynn): Thank you. Let's hear from France and Liz, then lunch.

M^{me} France Gélinas: Continuing on the same path, I can't fathom what you're telling me, that for the last 10 years we haven't been able to find funding for three beds in Stratford? This is—it took 10 years and we're still there?

Ms. Terri Sparling: That's right.

M^{me} France Gélinas: How could that be?

Mr. Andrew Williams: That's a very good question. I would say that it's probably because, again, it has fallen through the cracks. When the restructuring commission was going across the province, any new proposals were not reviewed. We were told, "Wait until the restructuring commission comes through." Once they finished their work, we were told, "Well, we've got to implement the restructuring committee recommendations before we can look at new capital." So there are a number of reasons, and we are where we are and we are really trying now—and again, as I mentioned earlier, with the visibility that the province is now giving this issue, we think it's timely to get this back on the agenda.

M^{me} France Gélinas: Are we talking capital costs, are we talking operating costs or are we talking both are not there?

Mr. Andrew Williams: Both.

M^{me} France Gélinas: So—

The Chair (Mr. Kevin Daniel Flynn): Sorry, France. We're actually over time already. Let's hear from Liz.

Mrs. Liz Sandals: I'm just struggling—and I'm not trying to be argumentative—to get what you mean by no access, because I think there's probably half of us here on the committee who would say, "There are no acute care beds for children's mental health in my community. There is no child psychiatrist in my community." The majority of the committee would be in the same situation. However, there are certainly kids from my community who might go to a residential treatment centre in Waterloo or might end up in a children's psych bed in London. Are you telling me that you are not allowed to refer kids to the children's psychiatric unit in London?

Ms. Penny Cardno: In Huron-Perth-Grey-Bruce, we are not one of the identified counties for which they must provide service.

Mr. Andrew Williams: Just to clarify, most communities in the province do not have child and youth beds in their communities, but they will have and they will be part of a region that accesses beds in Kitchener, in Hamilton, in Ottawa, in Kingston. Our regions have been specifically identified as not having that access. That's the point.

Mrs. Liz Sandals: Then I guess my follow-up question would be—

The Chair (Mr. Kevin Daniel Flynn): I'm not sure we have time for a follow-up unfortunately, but thank you—

Mrs. Liz Sandals: But what I don't get is, why didn't you redraw the boundaries?

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today. Your point was well made, and I think the committee would have loved to explore it further—and perhaps we can after we break a little bit—but I do want to be fair to everybody else, and everybody else kept to the 20 minutes. I know it's painful sometimes.

Mr. Andrew Williams: I'd like you to chair our meetings.

The Chair (Mr. Kevin Daniel Flynn): We've got to travel the province, unfortunately. We could spend the whole week here, I know that, but what I did get your point very clearly. Thank you.

We're adjourned until 1:30.

The committee recessed from 1207 to 1330.

CANADIAN MENTAL HEALTH ASSOCIATION, ELGIN BRANCH

The Chair (Mr. Kevin Daniel Flynn): The committee is back in session. Our first presenter today is the Canadian Mental Health Association, Elgin branch. Heather DeBruyn is here with us, the executive director.

Also, just to remind the committee members and perhaps some of the presenters who are here today that for the afternoon session we'll be having some interpretation in ASL. So if you could speak very clearly, very precisely, that would be great, and that goes for all members of the committee as well, just to assist.

Having said that, are we all set to go? Good. The floor is all yours. You have 20 minutes; you can use that any way you like. If you want to take the whole 20 minutes for the presentation, that's fine. If you want to leave something at the end for questions and answers, that's entirely up to you.

Ms. Heather DeBruyn: Thank you. I did have a handout, so there would be the full report. I just wanted to highlight a number of things as opposed to going through the whole report with you.

I wanted to talk about decent, affordable housing being a priority. Even though we, as the Canadian Mental Health Association in Elgin, do provide 62 units across Elgin county to 84 individuals, we find that this is not enough to meet the growing need. There is also a dire need to make funds available for ongoing maintenance of these units. A recent example cited to me was of a tenant who had epilepsy with grand mal seizures. Due to the violent nature of her seizures, she has a number of holes in the drywall of her apartment, and she's concerned about repercussions that might occur with her landlord. Equally, she does not have enough money on Ontario

Works to repair the walls, nor does Ontario Works have any discretionary funds that would cover those kinds of costs. So I just wanted to make the plea that money needs to be made available to help support individuals such as this to be able to maintain their market accommodations.

It's of particular interest that seriously mentally ill homeless individuals have a greater number of visits to emergency rooms and typically stay longer in hospital than the general population. Increasing the number of affordable housing units, as well as increasing support and supported housing programs, can dramatically decrease the need for unnecessary emergency room and extended hospitalizations.

I also wanted to talk about intensive case management and building trusting relationships to help individuals get the services they need. I know that some of the reports around the new investments in services note that they have not necessarily seen a dramatic increase in improvement at this point in time, but what I wanted to say is that sometimes it takes a long time to create a trusting, supportive relationship.

For my example, we work with the Low German Mennonite population in the east end of our county. It's very difficult to engage these individuals in the formal health care system, partly because of their transient nature and partly because they have their own health support systems within their culture. Our example is a worker of ours, Neil, who worked with a lady who was going blind. She'd never accepted services from any of our health care services in the past, and it was her belief that it was God's will that she lose her sight. After working with her for a couple of years—and it did take a couple of years—Neil was able to convince her to go to a specialist in London. He would go with her and stay with her for the whole time period that it took to go there. It was discovered that she had cataracts, and a simple surgery would remedy the problem. To this day, the lady still believes that Neil performed a miracle, and she does tell me that every time I see her. But by being supportive and taking the time to build a positive rapport and being sensitive to the culture, Neil was able to connect with this lady and get her the services that she needed to have.

When we first start working with individuals, not just the Low German-speaking population, but other clients who have not necessarily tapped into mental health supports in the past, there is a great deal of work that needs to be done with them to connect them to regular health care pieces, whether it be regular checkups, med reviews, getting them on medication in the first place or appropriate assessments. So when we start working with individuals for the first couple of years, the workup actually is more taxing on the health care system, but it's our belief that in the long run it will be beneficial for them, obviously, but also the health care system will benefit from that.

I wanted to let you know about our crisis safe bed program. We served a total of 230 individuals over the past year, and, of course, the crisis safe bed program is to avoid unnecessary hospitalizations and incarcerations.

We conducted a five-year longitudinal study with the three most frequent users of our crisis service and also the crisis services of Regional Mental Health Care. What we found was that in the two years prior to our safe bed program opening, these three individuals used a total of 145 bed days at the crisis unit at the psychiatric hospital, and for the two years after the program opened, they used a total, altogether, of 14 days, showing a dramatic reduction in the amount of hospital bed days when you do have other services like crisis safe beds available to your community.

Elgin county has a unique population. Partly, it would be from being in the backyard of the psychiatric hospital for over 70 years. I've included in your package a picture that comes from the southwest region of the Ministry of Health. It's a 2001 census report. The only difference would be that our population in Elgin has grown from 81,553 to 84,500, but 41% of the homes with special care in the southwest region are located in Elgin county when we represent approximately 6% of the southwest population. That, on top of the growing number of private homes in Elgin, means that we have a total of 335 beds in group homes and homes of special care that are specifically for the mental health consumers, which contributes to the drift factor that we have. We also have emerging needs with regard to the unemployment situation in St. Thomas especially. According to the chamber of commerce, St. Thomas has a population of 36,115, and we have lost over 5,500 jobs since July 2007.

There's a general concern in Elgin county with regard to the loss of expertise held at Regional Mental Health Care due to the extended length of time taken around the planning of the hospital closure and restructuring of specialized services to be located in London. There has been a tremendous delay in schedule 1 being moved from Regional Mental Health Care to St. Thomas Elgin General Hospital, and that has created gaps in services and strains on other community services, such as how the police have to transport individuals from St. Thomas Elgin General to Regional Mental Health Care. Because we do not have schedule 1, there has been increased pressure on our emergency room department at St. Thomas Elgin General as people needing to be admitted into Regional Mental Health Care have to be medically cleared through the emergency department before they can go out there.

There's also a general feeling in the community that there is an erosion of psychiatric services provided by Regional Mental Health Care as they have pulled back services to match their mandate. Elgin county residents have come to rely on the expertise at Regional Mental Health Care and feel that our ability to get immediate services for our clients has been diminished. As cited by one of Regional Mental Health Care's crisis nurses at a recent mental health and addiction meeting, the crisis unit is approximately 110% overused. The example was January 28, 2009: The 20-bed unit had 23 individuals on the ward.

I also wanted to mention that yesterday a community consultation was held for the children and youth mental health in Elgin project. It was noted that mental health services were effective in Elgin, just too few. Dr. Bertoldi was there, and she cited issues with navigating the mental health and medical system. Her example was a child taken into the general hospital for an overdose, the overdose being defined as medical and the cause of the overdose being defined as mental health. The psychiatrist would not touch the child until they had been medically cleared and the medical team did not want to touch the child because it was a psychiatric problem.

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She further stated that we do not have the proper facilities in Elgin to deal with these patients as they have tried in the past. In this particular case, the child tried to commit suicide on the general hospital ward, where there wasn't the relevant expertise to help avoid that situation.

There's a need for dedicated crisis beds in Elgin to stabilize and assess children locally through a schedule 1 facility and then be transferred to a regional service, if need be. There's also a need for a well-articulated plan to ensure that the transfer of services from Regional Mental Health Care to a schedule 1 at Elgin General includes appropriate levels of service and expertise that we know already exist at Regional Mental Health Care, and to ensure that that expertise remains here in the county for our consumers.

That's an overview. I have given you more detail in your packages, and I've also included the Network magazine, which does talk about mental health in an economic decline.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much. You've left about 10 minutes for questions, which is great. We're going to start with France.

M^{me} France Gélinas: I tried to read your map while you were talking, and maybe it's because I'm looking at it too quickly but I can't figure things out. What do the "H" and the "B" mean?

Ms. Heather DeBruyn: The "H" is the number of homes, so there are eight homes in Elgin county that are homes for special care. And "B" is the number of beds. There are 153 specialized beds for homes for special care.

M^{me} France Gélinas: And "P" was the population, and you said that the population has grown.

Ms. Heather DeBruyn: Yes, and I didn't go through and see how the population had grown throughout the southwest. I'm just presuming it's relatively the same.

M^{me} France Gélinas: I think you mentioned 5,500 job losses since 2007. Has this translated into an increased demand for your services or do you deal with a population that didn't get affected?

Ms. Heather DeBruyn: We haven't actually seen much of that yet. The chamber is predicting that in 2010 there will be a dramatic impact on services needed for that population, but they're not seeing it at this point in time. It's my understanding that Regional Mental Health

Care has not seen an increase in people using their crisis unit at this point in time.

M^{me} France Gélinas: You'll have to forgive my lack of knowledge of the geography. I'm trying to figure out if Elgin is a part of the geographical area designated under the French Language Services Act to provide services in French, and if so, if you know of any services for the French-speaking population of this part of Ontario.

Ms. Heather DeBruyn: It's my understanding that we're not under that act. Predominantly, our next largest population in Elgin would be the Low German-speaking Mennonite population.

M^{me} France Gélinas: Thank you.

The Chair (Mr. Kevin Daniel Flynn): The next speaker is Helena.

Ms. Helena Jaczek: I'd just like to go into the intensive case management aspect where you talk about building a trusting relationship and so on. Have you any experience with peer navigators through the system? We heard earlier today from Allan Strong of the Self Help Alliance, pointing to the value of someone who's been there who can help somebody else.

Ms. Heather DeBruyn: We do have a psychiatric network in Elgin county, and we do partner with them as well. They would do the peer support for that. We also have some staff hired who would be peers as well, under our regular intensive case management program.

Ms. Helena Jaczek: So you found it useful?

Ms. Heather DeBruyn: Very useful. There's certainly a difference in the perspective of being able to talk to somebody who has already been there, around what to expect and the hope and the recovery process. Definitely. I promised him I would come in and say "ditto" to his presentation.

The Chair (Mr. Kevin Daniel Flynn): It's a set-up. Maria?

Mrs. Maria Van Bommel: Just one quick question. I'm going back to the same map that France was just referring to as well. When we talk about beds, is that adult and children's beds or strictly adult beds?

Ms. Heather DeBruyn: Strictly adults' beds.

Mrs. Maria Van Bommel: Strictly adult beds.

Ms. Heather DeBruyn: Yes. It would be the 16-to-65 umbrella from the Ministry of Health.

Mrs. Maria Van Bommel: Do you have a similar breakdown for children?

Ms. Heather DeBruyn: No, I don't. Predominantly, our organization is working with the adult population. We do partner with Oxford-Elgin child and youth services for 16- and 17-year-old individuals, and then they partner with family and children's services and other people who were around the table yesterday to deal with children's mental health.

Mrs. Maria Van Bommel: Thank you.

The Chair (Mr. Kevin Daniel Flynn): One more question from Liz, and then Sylvia.

Mrs. Liz Sandals: You mention on page 7 a crisis safe bed as cutting admissions, but I'm not sure exactly

sure what you mean by a crisis safe bed. Could you explain, please?

Ms. Heather DeBruyn: Our crisis safe beds are for anybody in Elgin county who has experienced a situational crisis or needs a safe place to go. If you're homeless and you're in St. Thomas and you need a place to go, then we would provide a bed for you to go to.

Mrs. Liz Sandals: And give me an idea of what sort of a place where these beds are located.

Ms. Heather DeBruyn: Right now, we have them in three different existing group homes in Elgin. We have one that is all-female, we have one that's all-male and then we have one that can be either male or female.

Mrs. Liz Sandals: Okay, so this is like an emergency bed in a group home that you have.

Ms. Heather DeBruyn: Yes. And the maximum stay would be five days, because our workers would work with them to get them to a more long-term place, and some of these group homes have different types of beds that they could then move into. We have a number of apartments that we would look—if we had vacant apartments or market accommodations.

Mrs. Liz Sandals: Okay, thank you. That's very helpful.

Ms. Heather DeBruyn: It's a non-medical component.

The Chair (Mr. Kevin Daniel Flynn): Sylvia?

Ms. Sylvia Jones: As you move forward and are watching the change with London Health Sciences and St. Joseph's Health Care—we had a presentation from them earlier today, and it is my understanding that they are anticipating a net loss of 67 beds with the transfers. Does your organization have a concern or a comment that they would like to share with the committee about that change?

Ms. Heather DeBruyn: That's why I wanted to mention what the information was that we received from Regional Mental Health Care—the crisis nurse saying that they were consistently over-occupied in their beds, running 23 when they only have 20 beds, because the plan that had been put in place in the past was that 15 beds would move to the schedule 1 at St. Thomas Elgin General Hospital. So there is a general concern that 15 beds, which was the allocated number in the 1990s and early 2000s, may not be an adequate number for Elgin county, and it does not include beds that would be available for youth.

Ms. Sylvia Jones: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Any further questions? Being none, Heather, thank you very much for coming today. Your presentation was very well received. Thanks for taking the time.

Ms. Heather DeBruyn: Thank you.

ELGIN ST. THOMAS RAISE COALITION

The Chair (Mr. Kevin Daniel Flynn): Our next presenter of the day is the RAISE committee, represented by Jessica McKillen and Ron Elliott. Come forward,

Ron. Make yourself at home. There's some water there if you need any water. We'll get you all hooked up here.

You'll have 20 minutes like all the other delegations that we're hearing across Ontario. You can use that any way you like. We found it's better if you leave some time at the end for any questions that the committee members have. Other than that, it's all yours. If you'd speak maybe a foot away from the mic, apparently that works better as well. And if you could introduce yourself at the start of the presentation. Those are all the rules I have.

Ms. Jessica McKillen: My name is Jessica McKillen and I am the youth prevention worker for Addiction Services of Thames Valley. As you have mentioned, I have Ron Elliott here with me today. He's a pharmacist and the owner of Applegate Consulting. We are both here as representatives of the RAISE coalition, and I'm going to break it down. I'm just going to give you specifics on the RAISE coalition and then Ron is going to address some of the key points and factors that we've collaborated on to bring to you today.

As I mentioned, the RAISE coalition is a committee formed in Elgin and St. Thomas, and it stands for Reducing Addictions—Increasing Safe Environments.

I'm not going to go over our vision. It's pretty holistic of that. We want to see the harmful effects of substance misuse abolished from our community.

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Our committee formed in 2008 and we had a community meeting to discuss prescription pain medications. Once the committee had come and formed, we decided to address all substances and then incorporate mental health, as we can see that mental health is a predisposing factor for addictions. On this factor of concurrent disorders, we just wanted to stress as well that the percentage that you see here, 40% to 60%, is for the seriously mentally ill or severe dependence problems. With addiction services, the majority of our clients are—we see 18% with depression as our number one, and 6% with anxiety and post-traumatic stress disorder. Those aren't classified as severely mentally ill, but they are still predisposing factors for addictions.

Our committee consists of a variety of service providers and we are quite unique in upholding a range of enforcement, medical providers, social service workers and health promoters to get quite a collaboration working together towards the prevention of substance misuse.

We'd like to address the nationally recognized model for health promotion, and the four pillars are incorporated in the package that I have provided you with. We kind of summarized some of the activities and ways that we incorporate the four pillars of prevention through our committee.

As well, in your packages we've incorporated some of the tasks and projects that we've been addressing over the past year and a bit. Some of these have recently formed, so youth and teacher education was actually brought forward—one of the principals came forward to our committee and requested a presentation on the upcoming trend that they were seeing with OxyContin—

providing education as it arises around new trends. The PIER project utilizes peers, information, education and resources to empower youth and give them a voice to speak out about illicit substance misuse.

As I mentioned, I'm going to pass it off to Ron. The committee has collaborated with all of our expertise around the table and summarized three key factors for your consideration today.

Mr. Ron Elliott: Thank you, Jessica.

Good afternoon, committee. Thanks for giving us the opportunity to present to you this afternoon. As was mentioned, we bring together a coalition of people from various aspects, both volunteers and employees, to try and bring this issue to both your and our communities' attention. Our focus is to increase the support for prevention and health promotion, and we do use the reference that prevention is in fact a key pillar in the health community model.

It's hard to believe that prevention funding will save dollars by keeping people out of the treatment and emergency facilities. At the same time, we think it's important that we increase awareness of and access to existing services. I heard the last speaker speak about navigating the services, and that can be a real challenge for a number of people in the community.

To expand on a program that currently exists, there are programs like Heartspace, a program designed to support and educate parents and pregnant mothers with substance misuse issues in the rural and county areas. This program works on prevention in a generation-to-generation model and has been very successful.

We need to have more health promoters available to do in-service training—or train the trainer, if you will—so they can present information to agencies and service providers, educators, youth and communities. That in turn frees up the clinical staff so they're not being pulled away from seeing clients in order to do presentations and attend these various meetings. This will reduce the stigma, we hope, and break down barriers, creating more open dialogue amongst people with mental health and addictions to get the services from existing supports such as teachers and community groups, those who currently feel somewhat uncomfortable when approached with the topics of mental health and addictions.

We have to look at funding in all of these issues, and we believe that one-time and short-term contract funding is time-consuming for agencies and management to apply for and maintain. So appropriate compensation is lacking.

We need to increase the support for the retention of qualified staff to work in community-based agencies. Currently, community-based salaries are considerably lower than institutional-based salaries, so what we have, in fact, is a loss of staff as staff are harvested from community-based agencies to work in institutional agencies.

The importance of standardized assessment tools and training across all service providers for mental health and addictions to increase client access to service: Workers gaining this higher level of education for their positions are not being compensated. The addiction treatment

tools—admission, discharge and so forth—to identify the level, intensity and type of services that a client needs in addiction treatment services must be emphasized. Common assessment of need to identify mental health needs of clients is required to better service and direct treatment of care.

Just to give you a couple of examples, the deinstitutionalization of the mental health system has increased the number of clients with severe mental illnesses accessing community-based social services. Social services staff are then put in a position where they are now doing the work that hospital staff previously did. Agencies and service providers are seeing clients with layered and more complex issues across their realm of influence and accessing their services.

It's interesting to note that when police are called to assist with a mental health or addiction crisis, they often dispatch two police officers to attend. The officers are then utilized to escort the client to the hospital and remain with that person until they are attended by a physician. Many times these officers have to wait in the ER until the client is medically treated or is no longer intoxicated. Clients are then discharged from the hospital without having been connected to any community support structure. This was sometimes referred to as "treat 'em and street 'em." So they have a short interaction with the health care system and they go back out on to the street, on their own. That can lead to, and does lead to, recurring incidents with the same client.

London CArES is a municipally funded program that allows a worker to attend and connect with the clients in the situation, freeing up the police to return to their active duties while then connecting the client to resources that provide a continuous support. They reference "governments needing to work together to obtain success in the healthy community model."

We looked at some of the load in the community when our group came together, and it seems that the Elgin county worker is beyond maximum capacity, often with a double caseload. This demand exceeds the supply of staff, and certainly problem gambling is something we've become more aware of and have seen in the community as well.

As was mentioned, I'm sure, by other presenters, Elgin-St. Thomas has a noticeable economic situation. This has led to a large impact on the community social service structures in the area, and we can predict that it will only become greater in the future. When people lose their jobs, they lose their benefits. Sterling was a large employer here in the city of St. Thomas. When they closed—all those unionized factory workers are now looking for other sources of income. Workers and their families who were accessing services under the benefits of these positions will be orphaned from private supportive services and needing to access community services, and thereby, entering the public system as their separation pay and EI benefits run out.

Elgin has a high population of children and a very high population of unemployment. Also, to clarify the

slide, some 51% of the youth in this county have not completed high school, and that's a concern.

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Funding has not been adequate to support the increase in numbers, so clients are having to access the emergency room for immediate care since it is often the only point of access to services. The social determinants of health show us that lowered employment and education resources increase poverty and contribute, in a correlated effect, to increase the likelihood of mental health and addiction issues. So when we track these trends, we see that the need for expansion of funding to include gaming support within gambling services as well, especially for youth, as an early prevention strategy has become a recognized gap.

So I'm going to stop here. Jessica and I will try and answer questions, Mr. Chair, and we have a number of members of our coalition with us today to help us. We really see a distinct, direct connection between addiction and mental health.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for your presentation. Any questions? Maria?

Mrs. Maria Van Bommel: We just heard an earlier presentation about the population of this particular area of Elgin and especially the German Mennonite population, and I'm really curious about your comment or your fact about the percentage of the population that have finished high school. Especially looking at the ages, I could certainly understand that maybe in the older population, especially when you had companies like Ford and Sterling to go to, there wasn't the urgency about finishing high school, but that you would have such a high percentage of young people between 15 and 24 who haven't finished high school—is that in part because of the mix with German Mennonites? I guess what I'm asking is, can you explain the number?

Mr. Ron Elliott: I'll defer to Jessica for that.

Ms. Jessica McKillen: That statistic actually came from a recent study from the Centre for Addiction and Mental Health. I think one of the facts that we need to address too is that a lot of times youth aren't even typically completed high school between 15 and 17, so there's a number there already. And I'm not quite sure how they did their measures across the population. They didn't break it down into groups like the Low German population in the Aylmer area.

Mrs. Maria Van Bommel: From your own experience, would you be able to tell?

Ms. Jessica McKillen: I would say that, because it is a farming community, sometimes it's not the industrialized areas that some of these students are going to but possibly the farming areas, to work in that particular field.

Mr. Ron Elliott: In my experience as a pharmacist and seeing these people come through the store, it just wasn't in their priorities. It seemed that education was such that it was more important for them to work with the families and with the farms as opposed to completing school.

Mrs. Maria Van Bommel: It surprises me a bit as a farmer, I have to say, because farming has become so complex. I don't think anybody could farm with just a high school education anymore.

Ms. Jessica McKillen: Ditto for the farming, myself. I think that when we look at farming, there are different levels of it as well. There are the owners of the property and then there are the workers and the hired hands that come in to help with that. I think a lot of the time that's what we're seeing some of the youth going into, working as the workers, not as the managers of the properties.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Jessica. Sylvia?

Ms. Sylvia Jones: I'm actually kind of curious as to how you got such a diverse group together to be studying some of these issues. We have a Safe Communities in our area, and I'd like to hear a little more about how your coalition came about, how long it's been in existence.

Mr. Ron Elliott: There's always been a concern—I shouldn't say always, but for a long time—with a number of us about addictions that arise from the misuse of prescription medications. So we have met off and on over the years in different groups to try and address the issue. There was a loose number of groups who were doing similar things, and we tried to bring those folks together in that earlier meeting in 2008. I have to give credit to the health unit here in our community who helped us bring that together and offered us meeting facilities. It was by invitation to emergency medical services, to the hospital, to independent pharmacy people, to addiction treatment people and so forth to try and find a way to wrestle this thing, if you will, to the ground, because the ongoing use of opioids, especially OxyContin and Percocet, has become a real community issue. We've seen that with a number of employment-assistance agencies and so forth who run conferences and conventions to try and address the same issue.

We have worked on a model to give to our city council, and we picked up an awful lot of information from Oxford county, who were very successful in bringing together a community statement just this past spring—last year, actually. They brought that together and they did the same thing. It was led by their city council, and they have, I think, 50 or 60 agencies involved in this coalition to try and address the issue. So we're modelling and, quite frankly, plagiarizing where we can, with their permission, some of the material from Oxford as well.

Ms. Sylvia Jones: Thank you.

The Chair (Mr. Kevin Daniel Flynn): France?

Mme France Gélinas: I have this piece of paper that goes through your four pillars to support a healthy community. You go through prevention, harm reduction, treatment and enforcement. I was just curious if you could give us more details as to successful programs that you've had on the prevention side. Some of them, like ESTPH, mean absolutely nothing to me.

Ms. Jessica McKillen: Sorry; that's Elgin-St. Thomas Public Health unit. Those are just existing services that

do education and awareness and preventive measures upon the request of service agencies and schools and businesses and things like that.

A success for us right now—I mentioned the schools approaching the committee itself, looking for education information about the growing trend of OxyContin. A subcommittee was formed, we presented to all the teachers and we've been able to formulate a nice partnership with that school to continue the education and support to the teachers to be able to train them on how to assist the students and create a safe area and space for them. It's an ongoing preventive measure, but we're now a recognized support in the community for them to contact us.

Mme France Gélinas: And what do they do at the Talbot Teen Centre?

Ms. Jessica McKillen: The Talbot Teen Centre has been formed in St. Thomas as an area for local youth to go to for recreation. They have computer banks. It's kind of a drop-in centre for youth that creates a safe environment where they're not out on the streets, so it's doing preventive education. They have guest speakers come in and talk to them about varying topics such as substance misuse, and I know that they had a presenter in recently about sexual assault.

Mme France Gélinas: And who funds them?

Ms. Jessica McKillen: I'm not quite sure. Sherry Ball is from Talbot Teen Centre.

Ms. Sherry Ball: Actually, we're funded by the United Way. Right now we're open Wednesday through Saturday. Hopefully in the future we'll be open seven days a week.

A lot of our population range from 12 to 18. Mainly they come from at-risk backgrounds, so we are seeing the youth coming in who have little to no support systems at home. Although we do see 12-year-olds, the majority of the kids we have are 14 to 18, and they are the youth who are typically already in the justice system a lot of times.

We are doing prevention work, having speakers come in and also peers come in. Actually, just the other day, we had a young man come in who is in Guelph at rehab there and wants to come in and tell his story about how he got addicted to OxyContin and tell that to peers and youth his age so that they can better understand. It's obvious, with our population, that youth talking to youth is really something that works well. We're too old and not cool enough anymore. So the younger the better.

We just got approved for a grant as well from the Ontario chiefs of police to run another prevention program for substance abuse.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming forward today, and thank you for your presentation.

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KERRY FERGUSON

The Chair (Mr. Kevin Daniel Flynn): Our next speaker this afternoon is Kerry Ferguson. Kerry, if you'd

like to come forward. Make yourself comfortable. I see you brought your own Diet Coke. Like everybody else, you'll have 20 minutes to make your presentation. You can use that any way you like. If there's any time left over at the end, we'll see if we can get a discussion going. You can speak about a foot away from the microphone. The floor is all yours.

Ms. Kerry Ferguson: All right. Thank you very much for this opportunity. I'm a psychiatric nurse at St. Thomas Psych, and I've worked there 23 years; 20 years on medium-secure forensic. I'm also an alcoholic who has been sober for three years. I really do appreciate the opportunity. From my heart, we don't have enough for either mentally ill or addicted people in the area and probably all of Ontario.

The Mental Health Act, over the years, has not allowed us to—you look back at the 1920s or even further than that; it was very archaic, what we did. But now we have people coming to our hospital and they watch TV all day. That's not helping them. They don't have to take medication. They refuse their medication. We had one lady—this was a few years ago. She was psychotic, and it took two and a half years, because she thought—she was very smart, though, and went to the Supreme Court of Canada and fought all the way. But that whole two and a half years of her life, we got to watch her be mentally ill, and it's very difficult.

There are not enough programs, even at our own hospital. I was going to bring up the community-based. We're trying to put them more out into the community, but there's not enough set up out there for them. As nurses, we've become quite apathetic. I'm glad I haven't. I still want to get these people help.

Many years ago, I started in London a group with family and caregivers together. That was too difficult because I was the only nurse there, and the families—I was hearing their stories of trying to get treatment for their loved ones, and the battle. That's what it is; it becomes a battle. I'm still friends with one lady and keep in touch, but with work and doing that, it was too much.

I know that it's costly to put people in a community too, versus an institution, but I don't know which way is better. With us being there we can see a decline, where, if they go out in the community, at first they might be seeing their nurse quite often, and then it slips. A lot of our patients are addicted too, and they'll start using and abusing and not using their medication; instead, they'll use alcohol and drugs.

The downsizing, which is happening all over: They're familiar with coming to the Psych—it's referred to as "the Psych"—instead of down the road, it's going to be at the General, a 15-bed unit. That's what they're comfortable with: coming to the Psych. It takes a lot to even admit that you're coming to the hospital, because of the stigma of mental illness and addiction. That's where I say, "More education." I educate people. My loved ones think it's like *One Flew Over the Cuckoo's Nest*—my friends and stuff. Well, that's not what it's like.

I'm just trying to think. What else? Long waiting lists. Like I said, I work medium-secure. We have people waiting in jail a year, sometimes, and they're just sitting and getting sicker. We are going to be building a new medium forensic unit on the psychiatric property; that was supposed to happen in 1999. It just keeps being put off as the facility itself caves in. It's very depressing, our hospital. There's plaster falling in. It's not pretty, and if you're in there for depression, it's kind of hard. I'm hoping that this will happen. They're now saying 2011-12, but they need also—they increased the beds because like the normal London Psychiatric and St. Thomas Psych, I think they're saying 180 are going to be placed at Parkwood. We have more than that, plus all the out-patients. It just doesn't seem like enough to me.

As far as educating family doctors and staff about mental illness more, the police are getting much more education—they really are—over the years. Before they used to think, "They're just nuisances," but it's not like that anymore.

I'm trying to think of what else. I could go on and on; 23 years of—I'll turn to the addiction part. As we all know, addiction is a disease. It's just like diabetes and cancer. It becomes progressively worse; I know how I was getting. It's also hereditary. I had an uncle who passed away in January. It was hard to watch. It was a slow suicide. There is nothing—I tried to get him to go into the Psych. We probably could have deemed him a danger to himself, but within three days, he's out. It's the revolving-door syndrome; that's what I know, as a psychiatric nurse, it is.

There are not enough services for addiction at all in St. Thomas-Elgin county. I know when I first called Thames Valley with my own situation, I was told it would be three to four months until I got to see a counsellor. I just wanted to go back out drinking. I was just like, "Oh, thanks a lot." It was a stab in my heart. I just wanted help and I couldn't get help. Thank God for AA. I turned to AA and it has helped me, because that's a support group. There are nightly meetings somewhere. But that's also difficult. There are people who aren't driving because of impairment charges—whatever. Or I look at people going to the cancer clinic—they're getting rides. It's all washed under the table, alcoholism and psychiatric illness.

I pushed. Being a psych nurse and kind of knowing the system, I called almost every other day just to get myself in for treatment. I got accepted; it was only two and a half months that I had to wait to see Thames Valley. I got to see a counsellor. I learned a lot, because there's a lot. Even though I'd been working this for 23 years, there's a lot I didn't know. AA, like I said, has really helped me a lot. While I was seeing the counsellor here in St. Thomas—and that was only like, Tuesdays and Thursdays; anything else you had to go to London for. I was pushing to go to a treatment centre, and she said, "No, they're too long a waiting list. You really don't need it," but I just wanted more. I wanted to learn how to live with this illness. That was hard too, because

it's just another fight. I'm pushing and pushing. There are a lot of people who don't have the fight in them to even try to do something like that. They'll just turn and go back out drinking. I've known six suicides this year: four people who worked in factories and two of our patients. They are increasing. The economy is really bad in Elgin county.

I'm pushing to think what else. I wrote little things down here.

That's the other thing. I heard these people talking about—especially the younger generation. We are seeing so many more out at admitting with—well, it's not as much as ecstasy anymore, but there are so many drugs out there—the OxyContin, the Percocets. The availability is just amazing. I look back at my life as a high school kid. We had marijuana—that was it. Now it's like every type of pill you can think of. They're all getting wrapped up in that. It takes over, and that's where I'm saying the medical doctor needs to be cautious with giving these to parents and stuff and really explaining how addictive they are, because I've known three or four 14- and 15-year-olds who have become addicted. It's just dreadful, because it takes a long time and a lot of education, because people want to escape, they want that high, they want to not have to think, and a lot of people are dealing with their own parents who have lost jobs and bad situations.

I'm just going to glance at my notes—just mainly, more services. More money is needed so much for psychiatric and addictions. I know it's not just here; it's all over. It really is, and it's increasing. I see it where I work, and I see it just talking with friends and family. I don't have any major answers, but I keep pushing.

1420

The Chair (Mr. Kevin Daniel Flynn): Okay. Why don't we try some questions, then, from the committee? It sounds like you're about ready for that. Sylvia, you're first.

Ms. Sylvia Jones: Thank you for coming and appearing, Kerry. I wanted to expand a bit on something you raised when you talked about your uncle's addiction and the example you gave right at the beginning. I hear a lot from family members and parents who want to be involved, want to be part of the process of rehabilitation. Can you tell me, from your experience as both a nurse and a family member, how we can do a better job of that?

Ms. Kerry Ferguson: It's difficult, because it is the person themselves who has to admit they need help, with mental illness or with addictions. I think more programs are needed. The stigma is the main thing, it really is. People don't want to say, "I'm an alcoholic" or "I'm mentally ill. I'm crazy." It would really help just having more programs available, and easier access. I went to a women's group in London every other Tuesday. Well, it was every Tuesday that I could have gone, but with my shift work, it was every other Tuesday. That was something I wanted; it was more on addiction. But there are so many people who can't drive to London, either economically, they don't have a vehicle or whatever. We need

more supports, more systems in place; just to say, "Here. Here's a list."

With my uncle, all I said was, "Here are all the AA meetings." We argued a lot about it, but the person has to decide they want help. There's really nothing—I wish I could have handcuffed him and brought him to the hospital, but I couldn't. He was dead in his house for six days because I stopped going; I didn't go see him the last year. It was too difficult, plus I didn't want to find him dead. I knew that was how he was going to end up. He was a schoolteacher all his life. Some people sit there and say, "Well, they're just an alcoholic." They think of a brown-bagger alcoholic. No. He was a brilliant man. He had life in his hands—my grandparents' farm is 180 acres. It's very close to my heart, both psychiatric illness, because I work there, and addictions. More programs—more.

Ms. Sylvia Jones: I got the message.

The Chair (Mr. Kevin Daniel Flynn): Thank you, France?

M^{me} France Gélinas: In other comments you made, you talk about your work as a nurse and how some of the clients that you see have actually been referred a long time ago but end up spending a long time in jail before they actually get to be treated. Is this something new? Is this something that has always been there?

Ms. Kerry Ferguson: It has always been there.

M^{me} France Gélinas: What kinds of delays are we talking about?

Ms. Kerry Ferguson: There has been up to a year. Recently, I heard it's three to six months.

M^{me} France Gélinas: How long would you say the clients stay in your unit? You're medium, you said.

Ms. Kerry Ferguson: Medium secure, yes. It's usually a year to three years.

M^{me} France Gélinas: A year to three years? Is that the length of their sentence or the length of their treatment?

Ms. Kerry Ferguson: They have a review board every year which gives recommendations on if they should go on to minimum security, on to the next level, or sometimes be completely discharged. Usually they go to minimum security from us and then to the community.

M^{me} France Gélinas: What kind of catchment area do you cover?

Ms. Kerry Ferguson: From Windsor to—I'm trying to think—up Owen Sound, Woodstock. It's a huge area.

M^{me} France Gélinas: The whole southwest?

Ms. Kerry Ferguson: Yes.

M^{me} France Gélinas: I had one more. You talked a lot about stigma and how that has to change. Have you come across any programs or solutions where you said, "I think this could work"?

Ms. Kerry Ferguson: Just education. You know, people accept that if you've got cancer, you go get treatment for that. You're seeing it out there in literature in doctors' offices, in the paper. It just needs to be more education for everyone now.

M^{me} France Gélinas: To be more visible and be more out there in the mainstream.

Ms. Kerry Ferguson: Yes.

M^{me} France Gélinas: Okay. Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you, France. Anybody from the government side? Helena?

Ms. Helena Jaczek: I've been thinking a little bit about concurrent disorders. We've heard that of mental health patients, some 40% to 60% have addictions. What about the reverse? What about people with addictions—and I'm thinking particularly of, say, the teens who are now so exposed to chemicals that they are just experimenting with. Would you know from your experience how many are getting involved to begin with because of some underlying mental issue and how many are just kind of, "Oh, I'll try this," and then they get hooked?

Ms. Kerry Ferguson: I would say, as a guess, a fairly large percentage, probably 20% to 25%, because that's what the alcohol or drugs do, is keep—and that's the age group to become schizophrenic too, 15 to 20, and if they're hearing voices, then at least the alcohol or the drugs will take that away. We had an addiction program at the Psych. I'm trying to guess—it's been quite a few years. It was taken away from us; it's at London. It's called concurrent disorders. But there are so many I have met with AA and throughout my years who have said, "That program saved my life." It was a 28-day program. They went to it and they were locked in. They weren't allowed to go home and stuff. But they worked. They worked hard and learned a lot. And now the concurrent disorders program at London is going to become a day program. You say, "Oh, it just doesn't"—but I do believe there's quite a big percentage, especially that age group, because that's when schizophrenia does hit. Also, when they start taking these things, it can cause mental illness because of the chemical imbalance. Drugs and alcohol can cause mental illness.

Ms. Helena Jaczek: So they're both really very entangled.

Ms. Kerry Ferguson: Yes.

The Chair (Mr. Kevin Daniel Flynn): Do we have any further questions? We've got about a minute left. Maria?

Mrs. Maria Van Bommel: It's a bit of a personal question, so if you're not comfortable in answering, I could certainly understand that.

You say you've been a psychiatric nurse for 23 years. What drives you? What motivates you, in 23 years, to stay in that field? Certainly, as a nurse you could change to another specialty at any point and be very welcome anywhere in the health care system. So what motivates you and keeps you going day to day?

Ms. Kerry Ferguson: I think just the hope to see them get better, and I have seen so many over the years. They are a totally different person from when they're mentally ill to when they are on their meds and living in the community and they become just part of society. That just gives me the hope. Seeing them get better is the main thing.

But as I said, it is a difficult profession. You feel like you're banging your head against the wall. We've always said, you know, it's a revolving-door system. A lot of it, I do believe, is the stigma and stuff. Somebody can't walk out from a psych hospital and say, "I just got treated for mental illness," whereas if you walked out from the cancer clinic and said, "I have cancer," everybody would be saying, "Poor you." It's hush-hush, right?

Mrs. Maria Van Bommel: Thank you for your years of dedication.

The Chair (Mr. Kevin Daniel Flynn): Thank you for coming today, Kerry. It's really appreciated.

Ms. Kerry Ferguson: Thank you all.

DAVID SIMPSON

The Chair (Mr. Kevin Daniel Flynn): Our next presenter today is David Simpson. David, if you'd come forward and make yourself comfortable. You've sat through a few of the presentations now so you know what the rules are. You get 20 minutes. Use it any way you like. If you want to leave time at the end for some discussions, that would be appreciated. Speak about a foot away from the mic. It's all yours.

1430

Mr. David Simpson: Good afternoon, Chair and members of the committee. Welcome to St. Thomas and thank you for coming to us and to our community to afford us the opportunity to participate in the process. I think we've heard some excellent presentations both today and in other locations across the province.

I appear here today as a mental health advocate and human rights advocate with more than a decade of experience working with those who are most vulnerable amongst us: those with serious mental illness. I've learned some important lessons during that time.

Individuals with mental illness have been my teachers, my mentors and my inspiration. They've been pioneers, explorers and trailblazers, often willing to challenge a system that has treated them poorly by at times violating basic and fundamental human rights, failed to listen to their concerns or take their wishes into account. It has treated them against their will and failed to see the humanity and potential within them. But we must remember that they dared to challenge the system, to stand up for their rights and to be recognized as people first, who happen to have an illness. They are not their illness and they are more than their diagnosis and the symptoms that are so liberally applied to it. There has been a history of human rights abuses, social injustices, of being exiled from their own communities and tucked quietly away in asylums. It has often been an existence of loneliness, despair and isolation, shunned simply because of their illness and the stigma and discrimination so often associated with it.

But things have changed and people are now more willing to tell others of their mental illness, their struggles and what they need as they travel along their personal road to recovery. We have come so far, but we

still have so far to go before we can proudly say that as a community we are understanding, accepting and inclusive of all members of our society. It has often been said that a society is judged by how it treats its most vulnerable citizens, and I'm wondering today, will history look upon us kindly or judge us an uncaring and callous society?

Individuals with mental illness want the same things in life as every other Ontarian: to have a family, a home, a job, to love and be loved, to be able to provide for their families, to worship and express their spirituality, to be well and stay well, and to participate in the community to the extent that they are able and wish to. But individuals with mental illness must also be welcomed and embraced by a community that is willing to support them as they embark on their personal journey of wellness and recovery, and to provide them with equality of opportunity and a sense of belonging and recognition that the world is a better place because of what each of us has to offer to others.

We are those individuals. There is no "us" and "them," it is "we," because any one of us might experience mental illness at some point in our lifetime. It is for this reason that we must always apply the "family test" to all of our actions and how we treat others. The test is really simple: If this were my mother or father, my brother or sister, my grandmother or grandfather, would this be good enough for them? Because if not, then why do we expect that it is suitable and appropriate for someone with a mental illness? Let's always apply that family test before we speak or act.

I hope that both your committee and the minister's mental health and addictions advisory committee will work collaboratively to provide guidance, direction and visionary leadership in shaping a true mental health care delivery system that is responsive to the needs of all Ontarians, that is accessible, that provides equitable access no matter where you live in Ontario, and one that is truly person-centred, person-directed and person-focused. The system as I envision it would be based on the principles of recovery. It would be holistic, client-centred, client-directed, allow for self-management of illness and address all of the social determinants of health across the lifespan from cradle to grave. It will be a system where the client has the knowledge necessary to make informed decisions, to retain responsibility for their own illness and recovery, and they will be able to individualize their own plan of care. Currently we do not have a system, but rather a collection of services and supports that are often fragmented, disjointed, and fail to work collaboratively to the benefit of all who require service. It's also important to work with the new Mental Health Commission of Canada to develop a made-in-Ontario strategy to address our unique and special needs regarding stigma reduction, system design and integration, funding and service equity, and the development of a mental health strategy that is integrated into the national strategy.

It's a very positive step that this committee was formed and that you will report back to the Legislature your findings and recommendations. I would urge you to consult and listen, and then act with both passion and conviction on what you have heard. Please don't think about simply formalizing or codifying what currently exists, but rather think how you can mobilize resources, provide visionary leadership and work with consumer-survivors to bring about transformational change to mental health care and treatment in Ontario. You have the opportunity to be a catalyst for profound change and I would encourage you to be bold, knowing that your actions will have an impact on mental health care for generations to come.

I believe that transformational change can and will occur if a strong foundation is built and four key cornerstones laid, on which the rest of the structure will be built. To me, the four cornerstones are: independent advocacy and rights protection services; inclusion of peer support and self-help; public education and stigma reduction; and lastly, addressing the social determinants of health from a recovery perspective. Let me address each of those four cornerstones in turn.

Independent advocacy and rights protection: Ontario needs to have strong and effective independent advocacy and rights protection service to protect the legal and civil rights of all individuals with mental illness, regardless of where they receive their care and treatment, hospital or community. A mental health rights advocate would be able to address individual case advocacy issues as well as work to address systemic issues across Ontario. The advocate would have provincial oversight and would be able to report regularly on the state of mental health in Ontario, identify gaps in services and work collaboratively with others to address these gaps. This is important, given that each local health integration network is going down their own path, and each is addressing mental health issues in a different way.

The mental health rights advocate would be a partisan advocate for their clients, empowering them to be involved in all decisions affecting their care and treatment, supporting them in gaining access to services that would facilitate and enable recovery, and working with them during transitions between levels of care, from hospital to community and community to hospital. This would allow continuity and seamless access to services while dealing with any inequities that might exist with respect to availability and utilization of services.

Many individuals with mental illness are vulnerable because of their life circumstances, the very nature of their illness and, at times, their inability to speak on their own behalf. The mental health rights advocate could give voice to these issues when necessary, and when the person is able to speak for themselves, they could support and strengthen that voice.

Advocacy done well improves outcomes, restores relationships and communication between clients and providers, and it allows them to be empowered during their recovery. Independent advocacy is essential as it

heightens transparency and accountability, allows the client to develop and refine new skills with respect to resolving issues and problems, and addresses inherent power imbalances between clients and professionals.

At the systems level, the mental health rights advocate could address issues related to barriers to inclusion, access to care and treatment, stigma, discrimination and human rights violations. However, to be successful, the roles, responsibilities and authority of the advocate would need to be enshrined in law, and ideally the advocate would be an officer of the Legislature, like the child advocate. Independence and authority would ensure the success of the role.

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Without legislation, the role could potentially be ineffective, as the advocate would only be able to make recommendations and rely on goodwill in order to resolve issues and facilitate change. The advocate requires authority to address issues, to make lasting changes and to hold people to account. Transformational change will only occur if the system is pushed beyond its comfort level, if it embraces change and a new perspective toward the people they serve, and if they understand that the system must become person-centred and holistic in its approach.

The second cornerstone, peer support and self-help: Transformational change will only occur when peer support workers and peer support specialists become equal partners in the mental health care system, when they are part of every team and every agency, and when their services become widely available to every consumer who wishes to have their support and benefit from their mentoring.

If we want to be bold and promote change, then we would demand that every agency, service or support that receives mental health funding be required to have peer support workers or peer support specialists on staff as equal members of the team. If they failed to meet this standard, their funding should be terminated. There will be those who will speak against the required inclusion of peer support workers, but there will be those who will embrace a can-do attitude and make it happen, to the benefit of all of those who seek services.

If we don't have enough peer support workers, then we can work with consumer-survivors and consumer-survivor organizations to train a workforce that is responsive to the needs of those to whom they will provide service. What a great employment opportunity for those who have progressed in their recovery and have the knowledge, expertise and life experience to share with clients, families, staff and health practitioners alike.

I also want to talk briefly about the importance of self-help and learning from others who have a shared experience. It is important that we not lose sight of the importance of self-help and how telling one's story can, in fact, promote recovery. Telling your story and sharing your pain and achievement with others allows you to develop inner strength and reclaim your life while increasing self-esteem, a sense of meaning and purpose, and self-

acceptance. Others can learn from these experiences, and it shows others that tomorrow can be better than today and that there is hope for the future. This is both empowering and liberating to those who have struggled along their road to recovery. Let's recognize the importance of self-help and provide the necessary funding to ignite a movement that allows people to help people.

The third cornerstone is public education and stigma reduction. The portrayal of mental illness in popular culture is often one that is negative, demeaning and dehumanizing. It has perpetuated the myths of mental illness and fostered a fear of the unknown. It is for this reason that the government of Ontario must immediately embark on a public education campaign to educate the public and professionals about mental health, mental illness and addictions. All too often, our system has focused on illness instead of wellness. We need to put the faces of mental illness before the people and to humanize it so that it is accepted as any other medical condition. Demystifying the illness and providing information will lead to the community being informed and knowledgeable, and hopefully acceptance will be the end result.

There's an urgent need for education for health practitioners and service providers because, unlike other areas of medicine, there is a legal framework against which all mental health care and treatment is provided. They need to know and understand mental health law to know how it impacts on care delivery and the rights and entitlements of individuals with mental illness. We cannot stop human rights abuses if service providers and the medical community don't fully understand the law and the rights of patients. I would encourage you to develop a system where such education is required and where broad-based public education campaigns are conducted regularly.

Information and discussion of mental health, mental illness and addictions should become a part of the curriculum at all levels of education, from elementary school to college and university. This will have a positive impact on societal attitudes toward mental health, mental illness and addiction.

Stigma reduction is key to making transformative change. We need to call it what it is: It is discrimination. As a society, we need to develop zero tolerance for those who discriminate against individuals with mental illness. We need to strengthen human rights legislation, adopt a mental health patient bill of rights and educate the community about the harmful consequences of discrimination and the impact on vulnerable people. We must engage consumer-survivors in providing the education and conducting the stigma-reduction campaigns. Only when people see themselves reflected in the faces of mental illness will they understand that "It could be me," and they would want to live in a community free of stigma and discrimination.

I would encourage you to require the involvement of consumer-survivors in all public education campaigns, in educating people about stigma and discrimination and in letting the community know that people can and do recover from mental illness. We must develop a positive

message about recovery and demystify the illness and the misconceptions that abound.

The fourth cornerstone is social determinants of health. In order to have an effective mental health strategy, we must address the social determinants of health, those economic and social conditions under which people live. We must deal with the lack of safe, affordable and decent housing. We must acknowledge that most people with disabilities in Ontario live in government-imposed poverty due to inadequate Ontario disability support plan benefits; that most individuals are either unemployed or underemployed; that most lack social, recreational, spiritual and educational opportunities; that most have experienced some form of stigma and discrimination; that many lack access to medical services; and that many don't believe that they live in communities that are accepting, understanding and inclusive. Most individuals want to have a sense of belonging, meaningful activities to engage in and to participate in the community to the extent that they are able and wish to. Citizen engagement and participation are key to recovery, as are having a home, a friend and a job.

We must provide greater supports to family units where a member of the family experiences mental illness and where it has an immediate impact on the family and the community at large.

If I had more time today, I would also address other issues that are having an impact on the mental health sector in Ontario, including: the lack of a full range of mental health services and supports in long-term-care facilities, in jails and in institutions for children's mental health; the criminalization of people with mental illness; the lack of mental health and drug treatment courts across Ontario; the disparity in services between rural and urban Ontario; the lack of mental health services in your first language; and the lack of knowledge about mental health law and patient rights. But I will leave these discussions for another time.

I believe that the four cornerstones I have identified this afternoon, if implemented, would create a solid foundation on which to build a true mental health system in Ontario. They would be a catalyst to transformative change and the creation of a person-centred mental health sector in Ontario. I would encourage you again to act boldly, to make tough decisions and to provide visionary leadership, as your work will have an impact on generations to come. Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you, David, for your presentation. We've probably got time for one short question. France, you're up.

M^{me} France Gélinas: I really like your idea of a mental health rights advocate. I'm starting to read more and more, but it is the first time I've seen it articulated the way you have. Are there other groups that are also advocating for a mental health advocate?

Mr. David Simpson: There are, and I think you would hear within the consumer-survivor community that there need to be both professional and peer advocates in

the system to support people at all levels of their recovery.

When the province of Ontario ran the provincial psychiatric hospitals, patients at that time had access to the Ombudsman if they had a complaint about the quality of care or their treatment within that institution. However, when those facilities were divested to local hospitals, they lost that right of complaint. So that is one thing that has had an impact on the system. There are times when people need not an ombudsman or a patient representative but an advocate, somebody who's there just for them and to support them with their issues and to hopefully achieve a win-win outcome.

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M^{me} France Gélinas: I also like the report on the state of mental health in Ontario, which you saw. Do you know if other jurisdictions do this, where you have somebody who has to report on the state of mental health with the next jurisdiction?

Mr. David Simpson: Yes, I believe there are other jurisdictions in Canada that do that. Part of my thinking here too is that we have an opportunity with the new Mental Health Commission of Canada to work in partnership—this committee, the commission and the minister's advisory committee—to come up with a made-in-Ontario solution that in fact will protect the rights and entitlements of people with mental illness and be there to support them across the lifespan, that whole cradle-to-grave concept.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today. It was appreciated.

STEVE ELSON

The Chair (Mr. Kevin Daniel Flynn): Our next presenter is the Schizophrenia Society of Ontario, London chapter. Steve, if you'd like to come forward. We do have a copy of your presentation. You've got 20 minutes to use any way you'd like. If you'd leave some time at the end, that would be great.

Mr. Steve Elson: I will. Good afternoon. My name is Steve Elson and I'd like to begin by thanking you for the opportunity to present my remarks today. I'll be speaking to three issues, but first I'd like to give you some personal background.

I'm a father of a son who lives with schizophrenia and has done so for nearly 15 years. Our son has been lost on the streets; in jail, charged and found guilty of an offence; he has been admitted to hospital and discharged without a diagnosis; and he has been totally psychotic and out of control while living at home, a danger to himself more than to others. Today that same person is happily married, has two children, friends, holds down a full-time job and is a productive member of society.

So, I'm here today knowing a bit about the good, the bad and the ugly from personal experience because I know that there is hope and that the right medication, together with the love and support of friends and family, an understanding pharmacist and psychiatrist, and a

meaningful purpose to life, as a package, can make all the difference in the world. My wife and I are also active members of the Schizophrenia Society of Ontario and have been for quite some time.

The three issues that I would like to highlight are as follows: mental illness as a chronic disease, family involvement in the treatment process, and separate but unequal access to services.

First, mental health as a chronic disease: For those of us who are involved with persons living with a mental illness throughout their life, this can translate into a 40- to 50-year commitment, given that most people with schizophrenia develop the disease in their late teens or early 20s. Let there be no doubt: We take a long-term view of this. As we sometimes say, "It's a marathon, not a sprint." Our loved ones can cycle in and out of illness; they can do well, but we are ever watchful and ever vigilant. In many cases, families are the primary support and social connection for their family member, especially if they live at home. This is a life-changing and a life-defining experience for everyone who is involved. Life can be richer because of it, but it certainly tests our capacity for compassion and understanding.

I say this because this is the context within which we live our lives. As a lifelong illness, some people will never be independent, while others will. Regardless of the progression or course it takes, it never goes away, as most do not fully recover to their pre-disease state. In terms of the health care system, we are always struck, sometimes laughably so, that it functions as if this is a disease or illness that can be fixed. Don't get me wrong; people do get better, but because a person leaves hospital or a service does not mean they have a place to live, money, skills, can function independently, manage money, stay clean, eat properly, get a job, have a social life or take their medication on a regular basis. The relative isolation of many health care providers from the reality of life beyond the walls of their organization, unit or facility, I think, allows this acute care, or fix-it, mentality to persevere, in spite of how it is contradicted by the life experience of families and others.

What needs to happen, in my view, is that the mental health system, especially for people with serious mental illness, needs to adopt a chronic disease model of treatment and support. It's a well-established model for chronic physical illness and conditions, but it's largely underdeveloped in mental health.

Family involvement in the treatment process: In spite of what I've already said about the impact of mental illness on families, families often feel like they're on the outside looking in on the treatment process. Last summer, I made a presentation to the Standing Committee on Social Policy that reviewed the PHIPA legislation, and I made the case that in provinces like British Columbia, there is a much more open approach to the involvement of family and friends, and information is more readily and consistently shared because they recognize the valuable contribution we make to the treatment process. Alas, such is not the case in Ontario. We know that we

live with the consequences of what the health care system does or does not do. We live and walk with our family members before, during and after any involvement they have with the health care system. By excluding families and friends—those who love and support the person with mental illness—not only does the system shortchange itself, but the ill person is shortchanged as well.

In large measure, with mental illness, the client or family should be redefined as being the entire family. We all live with it, directly or indirectly, and if this were acknowledged and acted on, it would fundamentally transform the mental health system as we know it today. Redefining the unit on which services are based would reframe the way in which services are provided, and it would open the door to a partnership and collaboration that we could only wish for today.

Separate and unequal access to services: My third and last point involves how the mental health system has evolved to be both separate and unequal. For example, community mental health services are chronically underfunded compared to community services for developmentally handicapped persons, and yet the client population has many of the same characteristics and challenges living day to day. It is a sad reality that the criminal justice system is developing programs and services that seem to be more responsive to the needs of people with a mental illness than the health care system—by default, really. It's hard to come to grips with the fact that criminalizing the mentally ill might actually open a doorway to services that they might otherwise not get.

The in-home personal care and support services available to people in Ontario through community care access centres are not available to people with mental illnesses, and yet somehow this systemic discrimination is allowed to continue.

With other cases, when people with a mental illness need access to specialized services, they don't get them. Just ask the police or family members what the hospital's emergency department is like when they bring their psychotic family member in for help. It's a sad reality that far too often, people who need help don't get it when they need it, and that somehow their own denial of their need for help, in spite of their psychosis or total lack of insight into their illness, can be used as just cause to deny them what they need. The right to be ill is a gross injustice to the ill person and their family, but it's one that gets played out every day in this province.

So what to do and where to begin to right this wrong, this social injustice? The first is to recognize and acknowledge the reality of the situation for what it is and not pretend that what we have today is in any way adequate. A chronic disease does not need to mean chronic pain and suffering, but for many, this is exactly what it means.

The second is to develop an approach to mental illness that actually works, building on the chronic disease model referenced earlier.

The third is to take mental health treatment seriously and provide incentives that will reward physicians, nurses and allied health care professionals to apply best practices and innovation to mental health services, in hospitals in particular, as they do in many other fields. It's a challenging field and it deserves the best of what society has to offer because we're talking about one of our most vulnerable groups of citizens.

I'd like to close by quoting from the 2006 Senate of Canada report, *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada*:

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"Family members who provide care and support to relatives living with mental illness and addiction face a twofold challenge. First, they must suffer with their loved ones through their daily hardships and use their limited personal resources to try to alleviate them. Second, they must contend with a mental health system that often excludes them from involvement in the information-gathering and decision-making processes while simultaneously leaving them to serve as the fail-safe mechanism to provide unlimited, unpaid care, filling in the cracks that open when any part of the so-called system fails.

"Family members who provide care and support to relatives living with mental illness have their own unique perspective on the" health care system "and its reform. They have shown the committee that despite their frustration and fatigue, they will continue to search for assistance for their loved ones and to provide it themselves when they come up empty-handed. The committee acknowledges the contribution to this study made by these individuals. Their stories are valid; their voices must be heard; their recommendations must be acted upon."

Thanks for your time and attention.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Steve—a wonderful presentation.

You've left quite a lot of time for some questions. Let's start on the government side. Liz?

Mrs. Liz Sandals: I'm really interested in your comments—well, on our page 3—"It's a sad reality that far too often people who need help don't get it when they need it and ... somehow their own denial of their need for help" leads you there.

I know I've dealt with a number of families who have been very concerned about a son, a daughter, a brother or a sister who's schizophrenic and is off medication. They see the warning signs, but yet they can't reintroduce the relative, the loved one, to the system to get the help that they know they're going to need until they go into total crisis.

Do you have any comments on what we should do to change that culture that sort of pushes the caring family member away?

Mr. Steve Elson: Yes.

Mrs. Liz Sandals: Would you like to share?

Mr. Steve Elson: Certainly, thank you. I think there's an important reality, and it gets played out many times,

and that is that the person who is ill can, in fact, fake wellness and that they can be quite "un-ill" and quite disoriented and delusional in many ways, but they're not so out of touch with reality that they don't realize where they're going or what might happen to them.

There is a capacity for a person to interact with a health care professional and present themselves as if they are normal and to say, "There is nothing wrong with me. I am perfectly fine. It's my parents who are at fault. It's all made up in their minds," blah, blah, blah. If the person is talking to them perhaps for 10 or 15 minutes, they will present themselves in a very realistic way. They will respond very appropriately. There would, perhaps, be no obvious hint that the person is not well. But if the person was to sit down with them for an hour or perhaps go a day later into the family, there would be a very different picture that would play itself out.

Sometimes, that's exactly what happens: The situation is such that the way in which the person presents themselves in an emergency situation, where they're very uptight because it's a completely new environment to them, they're meeting strangers, they're very nervous, they think that something very bad is going to happen to them—they can present themselves in a way that, for the service provider or for the emergency physician or for the health care professional, is normal.

I think one of the key factors is, would we be able to take the information that family members or friends, who have a much more intimate and personal understanding of what has led to this situation, the action taking place in the present—for them to be interviewed and for their information and their reality and their understanding of the situation to be factored into the decision-making that the health care professionals are making.

As an example, when our son was taken and was presented for a consultation in what used to be the Clarke Institute of Psychiatry in Toronto, my wife and I were interviewed, as was our son, and it was the combination of the psychiatrist talking to us and accepting the reality of life as we presented it as parents, together with our son's behaviour, that led to the recommendation to have him admitted. But I think far too often that does not happen.

Mrs. Liz Sandals: That information is protected. Thank you.

The Chair (Mr. Kevin Daniel Flynn): Sylvia?

Ms. Sylvia Jones: I'm really pleased that you came this afternoon, because after access to care, how to engage families in the process is the number two issue that I deal with. I'd like you to continue on that same vein of what we can be encouraging, what we can be recommending to ensure the patient has their rights maintained, and yet still allow those individuals who want to be that circle of support to be engaged.

Mr. Steve Elson: Sure. Thank you. I don't know if you're familiar with the concept of the circle of care, but it's one that is used to basically describe and give access to information to people who are involved in the treatment process of an ill person. For the most part, health

care professionals who are actively engaged in treating a person are considered part of the circle of care; families generally are not, unless the family member is legally defined as a substitute decision-maker or has a legal status with respect to having access to information. So I think one of the things that would be very helpful would be to make it possible for family members in general, particularly if the ill person is living with the family and is obviously actively engaged with the family, to be considered part of the circle of care without having to assume a legal status in order to gain access to information.

There's obviously a delicate balance between the right to privacy and the right to information. What we find is that, as I referenced again in the BC situation, there's an opportunity where in legislation, family members and friends who are involved with the ill person have access to information where it's clearly going to make a positive impact on the continuity of care. They are recognized as part of providing care. Now, we're not professionals, but the acknowledgement is that we are part of the system; we're part of a team of individuals who in fact have this person's needs and interests at heart. So formalizing and recognizing that role for family members, I think, would be a significant step forward.

The Chair (Mr. Kevin Daniel Flynn): Thank you again, Steve. France?

M^{me} France Gélinas: I guess I knew this, but it never dawned on me until I heard you say it that in-home personal care and support services will be denied to you if you have a diagnosis of mental illness. So if you have a hygiene issue and you need somebody to help you bathe or if you have ADL, activities of daily living, that you would need an occupational therapist to come to you for, if you have a diagnosis of schizophrenia, by example, you won't be allowed CCAC services, community care access centre services?

Mr. Steve Elson: That's correct.

M^{me} France Gélinas: It's as blunt as this? Because you have a diagnosis, you're excluded?

Mr. Steve Elson: That's correct. The community care access centres don't like it, but when they're asked that question, they are told—I suspect it's probably not a legislative requirement but a policy situation at the present time that they are denied from providing service to that population. You're quite correct.

M^{me} France Gélinas: Through your knowledge of and involvement with the Schizophrenia Society, had there ever been a CCAC with a bigger heart someplace that actually saw the light of day and helped those people?

Mr. Steve Elson: I suspect, like in any system, people find workarounds; they find ways. "Is there some other diagnosis or some other presenting problem that will give us an excuse to come and provide you with service that you might not otherwise get?" But it's kind of under the table or not explicit. It's a very troubling situation.

The expectation is that in fact there are alternate community services available to people with mental

illness elsewhere in the community, and that's simply not true.

M^{me} France Gélinas: All right. Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming, Steve. Thanks for presenting today.

Ms. Sylvia Jones: Chair, can I impose on our researcher to get a little more detail on the BC example and how they actually do that?

The Chair (Mr. Kevin Daniel Flynn): Absolutely.
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RICHARD CSIERNIK

The Chair (Mr. Kevin Daniel Flynn): Our next presenter is a professor from the School of Social Work, Rick Csiernik. Rick, if you'd come forward. Make yourself as comfortable as you like.

You've been here for the other presentations, so you know everybody's got 20 minutes. It's yours to use as you see fit.

Dr. Richard Csiernik: Thank you very much. I appreciate the time and the opportunity. My first internship as a social worker was as a constituency assistant for an MPP in Hamilton East, so I appreciate the enormity of your task at hand.

Just some context: I've worked in the addiction field for 20 years, including a 10-year, million-dollar-funded project looking at the issues of homelessness, mental health and addictions. I've been teaching addiction since 1987 and was one of the co-founders of the addiction studies program at McMaster University, which has trained more addiction professionals in the country than any other program.

Interjection.

Dr. Richard Csiernik: Sure, we can. I'll make sure I try to squeeze my 20 minutes in well for you.

The Chair (Mr. Kevin Daniel Flynn): Also, Rick, you'll find that the mics don't work very well if you're close to them and they don't work if you're far away, so you've got to be about a foot away.

Dr. Richard Csiernik: About a foot away? Thank you for that. I'm used to teaching walking around, so this thing—

The Chair (Mr. Kevin Daniel Flynn): We'll have to nail your feet to the floor for the presentation.

Dr. Richard Csiernik: Anyway, the opening dialogue was just how important and educated I am; that's all that was about.

I've read some of the presentations that you've received already online. I've sat and listened to some of the presentations on this afternoon, and much of what I have to say follows them, but there are two critical points I want to share with you that I share with all my students. They're greater than the sort of incremental issues that you'll deal with on a day-to-day basis, and they're of the more large structural issues. One is how we conceptualize the idea of addiction and mental health. This basic conceptualization hinders the way treatment is provided

in the province, how treatment systems are developed and how you create policy. The other reality that you're well aware of is that you simply do not have the budget to do the type of programming you need to do. One of the greatest issues we have is that there are at least 10 different ministries at the government level that somehow touch addiction and mental health, and they don't work together. The project that we've worked on in the last 10 years in the London area has been working on trying to break down some of those silos.

So again, my presentation's there. I've written a hundred journal articles; there are books. Your researchers can find me everywhere on the Internet if they need to, but what I want to share with you—

Interjection.

Dr. Richard Csiernik: Surely.

Interjection: If you'd just take a breath between sentences, that's all that's needed.

Dr. Richard Csiernik: It's one long sentence.

Addiction and mental health have three constituency components: a biological component, a psychological component and a social component. The training we do in this province is very good at dealing with the biological. We have wonderful medicines and we have wonderful detox centres for people in withdrawal. Counselling programs have grown tremendously in the 20 years I've been an educator. We are good at providing psychological counselling—not perfect. We have more insights; we have more programs.

The difficulty that my students encounter when they hit the field, the difficulty as researchers, is the coming together of the three elements: the bio, the psycho and the social. The most difficult one—and the one other presenters have spoken to you about—are issues such as poverty, issues of inadequate income and issues of inadequate housing. We did a wonderful study here in London that said that people would love to have treatment, but they'd rather have something to eat first; they'd rather have somewhere to sleep first. So you can get them to my students and they can counsel them, they can help them through detox, but you put them back on to the street, you put them back in an untenable situation and you undermine all the money you put into programming. The social context that we speak of in schools of social work are the wider structural issues that need to be put in place, or you're really wasting money.

And it's the same thing when you have competing ministries. Again, from housing to aboriginal affairs to seniors to health, obviously, to correctional services—they all have some connection to this field. Your goal, when you go back, is to have these ministries co-operate on this topic.

A huge project we developed at the University of Western Ontario was this intercollaborative, interdisciplinary work. We're literally putting down the doctors with the psychologists, the social workers and the OTs to talk together about patient-client care. This is my challenge for you: When you go back to the committee room,

back to the panel, how can you get these various ministries working together on this theme?

The rest is very straightforward. Everything that is on the forms comes from my own research and my own data, so it's empirically supported. Key, obviously, will be the continuum of care. You have this nice, beautiful blue diagram in front of you; a prototypical model. The largest issue, of course, is that this is a very standard model on continuum of care, what's necessary. There are very few communities in our province that have that. I live in Hamilton, I work in London; half a million people, 400,000 people, we don't have this continuum of care in our community. There are gaps. So as people come forward saying that we have consumer-survivors to support, we have family members to support, the professional services from community to community have been cut back. Again, there is not enough funding, but what can be done to coordinate what there is and to maximize what there is is the challenge that I put upon you as our elected officials.

Page 4 of the presentation just speaks to some contemporary issues that are necessary. Harm reduction, obviously, is a new part of our treatment of care since I joined the field 20 years ago. Controversy in prevention is always quite ironic. The initiative we speak to here: harm reduction initiatives like methadone treatment, needle exchanges and safe injection sites remain very controversial as prevention initiatives—quite unique in the field of helping, where prevention is seen as controversial or stigmatizing.

In mental health services, we have some excellent case management programming. When you move to the addiction field, that same type of service doesn't exist. Case management is probably the biggest deficit in the addiction dilemma. I come from a day when the Addiction Research Foundation and the Clarke Institute were different institutions. I lived through that amalgamation. They are related—obviously you've heard that—and yet they're integrated.

There's nothing functional about mental health. Often when people begin using psychoactive drugs, there's something functional about that; it serves a purpose. It's a negative, destructive purpose in the long run, but there's some functionality to it. Obviously, the issues of trauma are something we've come to realize. Trauma services are grossly neglected in the development of addiction services in this province. They emerged in the 1970s. The issue of trauma is a relatively new one. So they've not been integrated because of the different developmental cycles. So that's there, documented for you. Obviously, issues of diversity are great. We've heard different populations that we need to support and care.

The last thing I want to leave you with is the poor staff people who are working there. They come to me, they've spent four years in education with me and I teach them about 40% of what they need to be an addiction worker, to be a mental health worker, and then they go into the field and they learn very, very quickly. We're currently

doing a study of the trauma of counsellors in the field that actually should scare you. What they need is ongoing, continued support. It's so easy to put clients first, and for the counsellors, the social workers, the psychiatrists, the psychologists, the nurses in the field, there is a huge rate of rustout and burnout in this field. So, as you're considering the needs of clients, I'd also ask you to consider the needs of those supplying support, be they family members, be they consumer-survivors, but also professionals, and to ensure that they receive consideration for the type of work they give.

Those are the highlights. I'd be happy to answer any questions you have.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much, Rick. Thanks for your presentation. We're starting this time around with Sylvia.

Ms. Sylvia Jones: Actually, I don't have a question.

The Chair (Mr. Kevin Daniel Flynn): Okay, wonderful. Thanks. France?

M^{me} France Gélinas: I have a million. I didn't think I was going to go first.

The Chair (Mr. Kevin Daniel Flynn): You're second.

M^{me} France Gélinas: The first model you presented to us, the biological, psychological and social aspect, you call it "a phenomenon," I like it; it's very visual, and it's easy to understand. But did I hear you properly when you said that treatment is all for nothing if you don't have a roof and food?

Dr. Richard Csiernik: We did a study examining what stopped people from going to treatment, and it was very interesting. We did focus groups; we did interviews with 300 individuals who are homeless. Their concern was not with their addiction, their concern was not with their mental health; their concern was where they were going to eat today and where they were going to sleep today. A funny little example is that people chose a shelter by how good the meals were; they really didn't care where they were staying. They needed to eat and were hungry. Those core human needs need to be met before we can move to higher-order needs, which include taking care of your mental health and your addiction issue. So that's that core element. It's very Maslovian. It's nothing phenomenally new; it's just now proven with a study saying, "My basic needs need to be met before I can think of dealing with a mental health issue, before I can think about dealing with my addiction issue."

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M^{me} France Gélinas: Which is something we've started to hear more and more. When we hear about recovery, we hear lots about needing a home, needing a job, needing a friend.

Dr. Richard Csiernik: Yes. It's a basic issue of poverty. It also speaks to the need of the continuum of care in terms of having both residential programming as well as outpatient programming. I realize there's a huge cost differential. The issue about residential programming, though, is that it's actually cheaper than outpatient counselling when outpatient counselling doesn't work.

M^{me} France Gélinas: Then I go to your nice blue chart. I love the title: "Prevention and Health Promotion." I have asked a lot of presenters to give me a good example of primary promotion that works. Most of them go straight to early intervention, but are there—not early intervention, but strictly health promotion—disease prevention initiatives that are proven to be effective in the field of mental illness and addiction?

Dr. Richard Csiernik: I have a whole chapter for you—absolutely. You need some sort of strength in your life, and we've heard about family. Family strength is critical; success in education is critical; friendship relationships and social relationships are critical. You can have any one of those three and they can overcome deficits that you have.

There needs to be some sort of substantive success. We've just finished looking at a study of the role of culture and cultural norms, family norms, friendship norms, education norms—if there can be some sort of stabilization. The reason it's a bio-psycho-social model is that each individual will be strengthened by different elements. Why we talk about the continuum of care is that one program won't meet the needs of a group of children. You could have two young people, side by side—same family, same neighbourhood—and the one program will connect and the other will not. This is the whole notion of continued education, from kindergarten through to high school. We haven't talked about the workplace; in fact, once you hit the workplace, that is gone—so integrated ideas, of course, that build upon the various strength areas and address deficits. Again, I'd be happy to send you the chapter on that; it's well referenced with 300 resources.

One-off programs don't work. Someone coming into a classroom environment, saying, "Hi, I'm a recovering addict," for half an hour doesn't work. It needs to be integrated into the ongoing curriculum, which is why the Ministry of Education, of course, is a critical component of the administrative work.

M^{me} France Gélinas: Can you give us a reference by heart as to this chapter on health promotion—

Dr. Richard Csiernik: I will send it by e-mail to whoever would like it.

M^{me} France Gélinas: Okay. To our head of research.

Dr. Richard Csiernik: Absolutely.

M^{me} France Gélinas: That will work.

It just escaped me—it's something you just said. You were talking about it having to be ongoing—

Dr. Richard Csiernik: Ongoing and integrated.

M^{me} France Gélinas:—and a lot of it has to do with the Ministry of Education.

Dr. Richard Csiernik: Absolutely. I've worked with a variety of community groups who want to make presentations to school boards; the school boards have their own. There's so much information out there, where best practices exist, but we don't know what the best practices are. Again, I'd be happy to share that with you.

M^{me} France Gélinas: Okay. My last question is, is there any good work that you know about that focuses on stigma?

Dr. Richard Csiernik: Oh, huge good work. Most community services do it when they put in a treatment facility and a mental health program. They go around and talk to the neighbourhood and introduce them to real people. The second you personalize an addiction or mental health issue it becomes real. Again, I teach at McMaster, where a third of my students are in recovery, and I'd let them babysit my kids.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much, Rick. The next is Helena.

Ms. Helena Jaczek: I'm looking at your practice model: "Addiction is a Bio-Psycho-Social Phenomenon." Now, obviously many teens experiment with drugs, potentially addictive. Kerry was kind enough to elaborate from some of her experience that some of those teens no doubt are perhaps dealing with symptoms that are very uncomfortable, the schizophrenic potential precursors, whatever. Then, of course, there's this whole entangled mental health/addiction piece. But my real question is, on your psychological causes, would you say that there are some particular personality characteristics underlying a kind of—I don't even want to call them symptoms, but some sort of particular risk factors that lead some individuals to have a very major problem with addiction, as opposed to those who are able to kind of walk away?

Dr. Richard Csiernik: Absolutely. That's a brilliant question. It's the ongoing issue: Is there an addictive personality? That's a term we want to hear. The original thought was, yes, there is. The problem empirically is that when you have this set of characteristics, more people who have those characteristics do not have an addiction than do. So, yes, there is a grouping. What we're discovering is, the key element is some sort of trauma. It can be early childhood, adolescence—trauma can occur at any time. Trauma can occur as a senior. But there's some huge disruption. The correlations between sexual and physical abuse and substance use are beyond 50%, and thus my comment here about trauma counselling, which is not integrated presently into addiction services; they're distinct. We just finished a doctoral study at Western. A nurse spoke about the fact that she went to agencies and they said, "Yes, we know this is necessary for women particularly, but we don't have the funding for it; we don't have the time for it." So again, it's not that we don't know this; it's that the way the systems have evolved has not allowed for it.

So your answer is, yes, there are. There are certain traits and characteristics that are associated with them. Most are connected to trauma. We know trauma changes brain chemistry, so again, there's your bio-psycho-social connectedness when they come together.

Can we do some prediction? We can. If you tell me you were sexually assaulted at the age of 12, I'd say, "We'll put you in a prevention program, full bore, right now, because you have an 80% chance of developing an addiction issue." It may not be full-blown, but again, it

can impair your life so it doesn't come in the full richness it could.

Ms. Helena Jaczek: If I could just follow up on that, because again, like France, I'm always trying to think of the health promotion. The population-based strategies that you might use on a teen population: Are there any sorts of messages that could be used to kind of—obviously, on the trauma side those are dramatic situations. Is there any utility in trying to warn in some way?

Dr. Richard Csiernik: The best health promotion programs involve families with children. The greatest difficulty is finding a place for families to come in with their children. School-based initiatives—families with the most chaos in their lives are often the ones least engaged with their children. Those are the ones that are more susceptible. Again, I'm stereotyping, because as you well know, any family can be impacted by addiction.

You're asking how to maximize your health promotion dollars. Engage long-term, school-based, family-involved programs. I don't think you'll find anyone who's going to argue with me the fact that kids and families should be supported by the government.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Helena, and thank you very much for coming, Rick. It really is appreciated.

Dr. Richard Csiernik: My apologies to the audience for speaking too quickly. Thank you for your time.

The Chair (Mr. Kevin Daniel Flynn): It's your enthusiasm coming out, I think.

Dr. Richard Csiernik: Again, this is very important work. I want to thank you for volunteering for this committee. Those of us in the field appreciate it very much.

The Chair (Mr. Kevin Daniel Flynn): Thank you. Copies of your work are available on the table, I would assume?

Dr. Richard Csiernik: There are some copies there, and if I have a card, I will e-mail that to you this evening.

The Chair (Mr. Kevin Daniel Flynn): Thank you.

THAMES VALLEY DISTRICT SCHOOL BOARD MENTAL HEALTH AND WELLNESS COMMITTEE

The Chair (Mr. Kevin Daniel Flynn): If I can ask, then, the Thames Valley District School Board Mental Health and Wellness Committee to come forward. Cathy Johnston is the co-chair. We've also got Tracy Grant and Deb Reitzel-Jaffe. Make yourselves comfortable. You may not have been here when I announced that we have some ASL interpreters with us this afternoon, so if you could assist them by being very precise in your language and perhaps slow your pace down a little bit, that would certainly be appreciated by everybody.

Just like everybody else, having told you to slow down, I'm also telling you you've got 20 minutes, so we've got competing interests. If you could save a little bit of time at the end for any questions perhaps, that would be helpful as well. Thank you.

Ms. Cathy Johnston: Thank you very much for the opportunity to speak to your panel on behalf of the men-

tal health and wellness committee of the Thames Valley District School Board. Our committee is a diverse group of Thames Valley employees and community partners—

The Chair (Mr. Kevin Daniel Flynn): I'm sorry. I have one more rule. It's not my rule; it's Hansard's rule. They won't be able to tell who is who, so before you speak for the first time, if you would identify yourself.

Ms. Cathy Johnston: I am Cathy Johnston, the co-chair of the committee.

Our membership includes the superintendent of special education, a number of principals, several trustees, psychologists, learning coordinators, a representative from the Ministry of Children and Youth Services, and a representative from the Canadian Mental Health Association, and also from family and children's services of Elgin.

Our vision has not yet been clearly defined, but our committee focus has been twofold: (1) capacity building to improve mental wellness for our students and (2) attitudinal awareness and change.

Our committee representatives today, just a few of the members of the committee: Deb Reitzel-Jaffe to my right, a psychologist with the board; and Tracy Grant to my left, a trustee with the board. Again, I am Cathy Johnston, and I'm an elementary principal.

I'll now turn it over to Deb to make her presentation.

1530

Ms. Deb Reitzel-Jaffe: Thank you again for giving us an opportunity to meet with you today.

Just to shine a light on the importance of your meetings today, I'm a little later than planned in getting here because, as often happens in my week, I was called out to do a suicide-risk assessment on a grade 8 student at one of my schools, and it really underscores, I think, some of the themes that we are going to talk to you about today.

We did divide the three things that we want to focus on; we'll each focus on one of those three issues. I'm going to talk about the emphasis that we feel needs to be there on prevention and early intervention, and I was glad to hear some of that coming from our previous speaker as well, because I think it's so important. There is such clear research, literature, on the efficacy and the cost-efficiency of really putting your focus on primary prevention and early intervention.

Before I worked for the school board, I did train as a clinical psychologist. I worked at one of our hospitals in child and adolescent psychiatry. When I took the job at the school board, my colleagues were all so excited for me, and I was very naively excited as well, about all the work I would be doing in prevention and early intervention, because we were at the other end, only seeing kids who were quite severely along the way in terms of their mental illness. It has been quite disheartening—not that I don't enjoy the job; I quite do—in terms of the lack of opportunity to do that preventive and early intervention work, and it really is a shame. I find myself running from crisis to crisis, as I was doing today, rather than being able to get to do some of that early inter-

vention and prevention work. I'm looking for any assistance that we can get in terms of having the resources available so that we can do some of that work.

I think that there are a number of barriers to doing the prevention and early intervention work, and I'll highlight just a few of those. Sometimes it's a lack of awareness among school staff about early indicators of mental health issues. Sometimes minor issues might go unnoticed, especially with internalizing types of disorders. With externalizing disorders, sometimes those early symptoms, those early issues, are misinterpreted as discipline problems, and that's the way they're dealt with. So I think—

Interjection.

Ms. Deb Reitzel-Jaffe: Slow down? Sorry. I was going to say in the beginning that those things you asked us to do, none of those are my strengths—speaking slowly and clearly. I will slow down.

I think sometimes, just in terms of the training, the breadth of training, the amount of training that needs to happen to help staff to be able to recognize what those early warning symptoms of a possible mental illness are so we can catch it early, that's a problem.

I think even when they are aware—and we do have some excellent staff in Thames Valley school board; some of them are very aware. There's a real problem with a lack of mental health staff—primarily, that would be psychologists and social workers in our board—in the school system. Because there's not enough of us, what happens is that they only call me if they've got a kid totally off the rails, and they're just going to manage all the rest themselves, because they know I don't have time to deal with the more minor ones who are not a big problem for them yet. They're managing them. The problem is that they're not getting assistance or help, so they're worsening, and then when they are right over the edge and they can't stay in school or they're a danger to themselves or others, then I get called, like I did today.

The boy I met with today has been having problems since the end of last year with bullying, feeling left out, feeling lonely and feeling ostracized. I met with his mother after I did the risk assessment today. She was a very fragile, extremely anorexic and wasted-looking woman. The parents are separated.

Interjection.

Ms. Deb Reitzel-Jaffe: Slower yet?

The father is not working at all. The mother works a little bit. So look at all the risk factors we have. But when am I involved? When he threatens to kill himself. That's just the reality of not enough resources for us to be doing more of the early intervention, the prevention kind of work.

In terms of the lack of mental health staff, we miss the kids with more minor symptoms. That's one of the problems of doing that. We also miss the kids with internalizing symptoms. If you have a child that's very anxious and withdrawing, they're not very disruptive to the classroom. I don't mean this in a pejorative way of our teaching staff, but it does mean that they can cope with

them better than they can with the child who has got more of an externalizing type of a disorder, because they can't teach anybody in the class then and they are on the phone to me asking me to do something. First, the child that's more of an internalizer might miss a lot of school and might eventually even drop out of school, but you can still teach the rest of the kids, so they're probably less likely to get services. It also means we don't catch those internalizers early.

Often, when I see a child who has got anxiety issues, who's school-phobic, they might have been out of school for a couple of months before they called me in. Well, it's really hard to get a child back to school who has been out a couple of months. If I see them after two days of missing school, I can probably be much more successful getting them back in, but again, they know how busy I am, so they're not calling me. I'm not even faulting them; I'm just saying that there's a problem, I think, with the resources.

Another barrier has been a lack of mental health resources in the community. I think that there are some great models out there. I forget who the author is of the two inverted triangles—one stands this way and one's inverted—where it shows the community really spending all their time and their energy and their resources with the most ill children in the population, and less and less resources and primary prevention, as you go down, for the ones who are not as acutely ill. The school, in dealing with mental health with kids, would be the flip of that: We are spending most of our time on primary prevention and intervention, and those things fit nicely together.

One of the problems is the fact that we find a lot of the kids are not able to access the resources they need in a community. The boy I saw today is an Elgin county student. There's only one free service available for him in Elgin county. Our understanding is that the wait list is now four to six months. Because I determined that he's not going to harm himself today, he's probably going to just go on that wait list, and it will be four to six months, and there's nothing else for him. His parents do not have money to go privately for him, so he's going to probably go without service for four to six months, and his problems will escalate. So the lack of mental health resources in the community is also a significant barrier.

I'm just going to highlight one more, because I'm going over my five minutes. Another barrier is often the stigma of mental health, and that makes it really, really difficult for us. Even when the school picks up on some of those early warning signs, because of the stigma of mental health, it makes it difficult for us to encourage the parents to go to a community mental health provider. It's hard sometimes for them to follow through on that, as well as what I talked about before in terms of a lack of resources. If you don't have a car and your mental health service provider is quite far from your home, or if you live in Port Stanley and you have to go to Edgeware in St. Thomas, unless you have a parent who can drive you there, you're not going to get the service. I'm going to let Tracy speak more on that.

I think there are a lot of costs to missing opportunities for primary prevention and early intervention. The child with mental health issues tends to be very ill before getting help, which often results in a worse prognosis for the child's mental health. It results in significant social isolation for that child and a lot of loss of school instruction opportunities.

The situation is extremely stressful for parents, for the teachers and for other kids in the classroom. It happens quite often. We have parents calling in about a child in the classroom that has been aggressive and has hurt kids, and they want the kids out.

Interjection.

Ms. Deb Reitzel-Jaffe: Still too fast? Wow. This is my slowest.

Interjection.

Ms. Deb Reitzel-Jaffe: I trained with a colleague who also was deaf, and we used to have joint supervision. She could lip-read if it was just the two of us, but it drove her crazy because she said that I spoke so fast, that it was making her eyes really sore. So it's a chronic problem with me. I apologize.

I think the lack of prevention and early intervention services creates an increase for the need for more intensive services in our community, like day treatment and residential treatment. I think if we could be doing more primary prevention and more early intervention, hopefully we wouldn't have as many kids needing those residential and day treatment services. I think it's absolutely a much more ethical way, rather than sort of saying, "Until they're suicidal, I won't be seeing them." I'd love to see them early, before they're in such significant distress. How hard is that for kids? It's an awful thing to put them through.

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The final thing I'll mention in terms of the costs of not catching things early is just—when the mental health needs of a child are severe and under-resourced, it stretches the ability of teachers to meet the many other learning and behaviour needs of the kids in the classroom. The classroom is a really complex place these days. There are numerous kids in every class on an individual education plan, with everything from learning disabilities to physical needs to behaviour issues, which often include a mental health issue. If you have a child with a severe mental health issue in the class and it's under-resourced in terms of getting the supports they need, the availability of that teacher to manage all the other students and their needs is just so compromised.

In summary for my portion, I'm saying that we propose that the allocation of resources to school-based primary prevention and early intervention initiatives will result in fewer young people experiencing severe mental health issues, which makes this both a very effective as well as an ethical means by which to address students' mental health needs. A focus on broad-based mental health and wellness initiatives will benefit all the students in the school system, and the ripple effects of that will

extend to school staff, their families and, I think, the community at large.

I'm going to turn things over now to Cathy.

Ms. Cathy Johnston: Thank you.

I have agreed to speak to you today about the need to build teacher capacity, and I apologize for reading, but I wanted to make sure that I said everything that I needed to say in my time allotment.

I'm going to start on a bit of a personal note. As an administrator and as a teacher, I have experienced considerable struggles meeting the needs of children with significant mental health challenges. I've watched as parents have attempted to manage crisis after crisis and attempted to navigate limited or geographically inaccessible mental health resources. I've watched parents of children with mental health challenges struggle to keep their jobs as the school calls again and again to ask them to come and take their children home. I have watched as teachers experience incredible stress and anxiety in their efforts to address the behavioural needs of these children, often at the expense of learning.

As a parent, I have experienced having my own 10-year-old son become diagnosed with an anxiety disorder. Over the past year, my child's school has called me on numerous occasions to inform me that he is in the office, unable to go to class because he's experiencing thoughts of self-harm. Often, the trigger is his perception that a teacher has yelled at him or does not like him. We have sought private testing. We have visited the clinics of CPRI, after months of waiting, and the child and adolescent mental health care centre at the London Health Sciences Centre. We have spent hours in the emergency department of Children's Hospital, first for suicidal ideation and most recently for an episode of self-harm. We have stretched our schedules and personally paid for transportation to manage the shuttle of our son to and from a day treatment program. My husband and I struggle to balance the demands of our schedules with the needs of our child. We worry about our son's increasing daily medication dosage, and we struggle with helping him through the unfortunate side effects. Whenever I see the dark clouds pass over my child's face, I fear what may be yet to come.

I have the advantage of considerable knowledge about the education system as a principal and knowledge of community supports, and yet we continue to experience frustration in our attempts to address our own child's needs. I cannot begin to imagine the challenges facing parents who do not understand the school system or who lack the awareness of community resources and supports.

Educators touch hundreds of lives every day. Educators have the potential to change attitudes and perceptions of mental illness through their actions and beliefs and through their instructions. Educators have the potential to reduce discrimination and intolerance. Educators have the potential to prevent attitudes that may lead to continued stigma. An educator's reaction to the externalizing and/or internalizing behaviours of a child can have tremendous lasting impact.

The Ministry of Education has made improvements within the last few years with respect to new teacher preparedness. The new teacher induction program is a remarkable step forward to better prepare new teachers for student needs. Recently, mandatory special-education professional development days for all teachers offer the hope that the issues of mental health may be addressed under the umbrella of special education.

The TVDSB Mental Health and Wellness Committee firmly believes that all teachers are in need of additional information and training about effective practices towards prevention and early intervention. Our committee would like to see additional efforts from the Ministry of Education to ensure that all teachers receive further training and education in the areas of prevention and intervention. Training must be offered in our teachers' colleges, and further professional development needs to be implemented within our school systems. Our committee strongly believes in the value of preventive programs such as BMS training or the CASEL social/emotional learning program in preparing educators to effectively support students.

Teacher coaching and collaboration is beginning on a more formal basis and has tremendous capacity for changing practice and perceptions. We encourage you to work together with the Ministry of Education and the Ministry of Children and Youth Services to ensure that best practices are established and followed.

The Chair (Mr. Kevin Daniel Flynn): Thank you.

Ms. Tracy Grant: How much time will I have?

The Chair (Mr. Kevin Daniel Flynn): You have about three minutes left.

Ms. Tracy Grant: Okay—slash and burn.

The Chair (Mr. Kevin Daniel Flynn): To be fair, if you think you have more than three minutes, why don't you just take the time that it needs and ensure that everybody in the room is able to understand it.

Ms. Tracy Grant: Thank you very much. I timed it at five minutes and 20 seconds, so I felt that I would speak faster than I would like to.

The Chair (Mr. Kevin Daniel Flynn): We're getting almost ready to leave town, so I'm sure we've got five or 10 minutes that we can add on to the end of our day.

Ms. Tracy Grant: Thank you very much. I'm Tracy Grant. I'm pleased to speak to the issue of school as a hub for services and assessments for children attending school.

The school-as-hub model has been suggested in many government documents. In order to better serve children in our communities, there is a huge agreement with the view that earlier diagnosis and treatment is beneficial to our vulnerable children and youth. In fact, there are several studies showing that for many disorders, later diagnosis or an inappropriate placement or treatment plan can exacerbate their condition and lead to co-occurring conditions.

While school personnel are trained to recognize the signs of a learning disability and react to externalizing behaviours which can seriously impact the safety and

learning of their whole class, there are many conditions which do not respond to traditional behavioural interventions. Therefore, the traditional response to behaviour which might be beyond a child's control is often progressive discipline. Clearly, this leads to a vicious cycle impacting the child's self-esteem and ability to function normally. Even positive reinforcement in disregulated individuals sets up a negative spiral, as they are unable to achieve the reward they desire. Further, mental health issues characterized by internalizing behaviours are often minimized or completely unrecognized.

My background as a parent, foster parent, adoptive mom, service provider, school volunteer, and trustee on SEAC, as well as our mental health and wellness committee, has made me acutely aware of the difficulties faced by children and families in accessing appropriate services in the many communities encompassed in our board area.

Recently, our board approved a permanent line to address mental health for students. I would like to highlight two partnerships in our board which have benefited many children and youth and which, if expanded and more widely available, could improve the emotional wellness and access to treatment services for children in their community. We believe that this approach to mental wellness would decrease stigma, improve service, decrease wasted wait and misdirection time, and ultimately be more cost-effective.

The first model is the wellness centre at the West Elgin Secondary School. We previously shared the paper written by Dr. Varpalotai—

Interjection.

Ms. Tracy Grant: Wellness centre.

The Chair (Mr. Kevin Daniel Flynn): I'm starting to learn something here, I think. As people speak, their speed picks up, I've noticed, so if you could just keep that in mind. You're doing great.

Ms. Tracy Grant: We previously shared the paper written by Dr. Varpalotai on this collaboration, but I would like to share some specific information on its creation, maintenance, and services available. This is a partnership between the high school, the West Elgin Community Health Centre and the Elgin-St. Thomas health unit. The parent council was also involved in the planning and is represented on the ongoing wellness committee. The committee provides lunch-hour information sessions and has offered wellness fairs at the school. These activities promote the services of the centre and encourage healthy lifestyles.

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Many services are offered in private offices provided by the school, such as individual and group counselling, anger management groups and healthy living support, as well as a variety of health services through a nurse practitioner. The single-point access to local services allows students to seek help for many concerns in a confidential but coordinated way. The social worker reports working with up to 50 students a year individually and in groups, offering 18 sessions weekly, while

the nurse practitioner and dietitian see up to 20 students per week. In addition, the Oxford-Elgin Child and Youth Centre ran a group this year called SOS for youth who self-mutilate at West Elgin Secondary School. The wellness centre also ran a relaxation noon-hour drop-in program monthly, and had 40 to 50 students participate each month, all in a school of 515 students.

The students self-refer to the wellness centre services, and can be directly referred to outside practitioners as needed. This rural community has suffered a lot of tragedy in the past few years, and the services of the wellness centre help youth at the school be ready to learn and cope with a variety of health and mental health conditions. While this exact model might not be possible or practical in all situations, it certainly improves access to services for students of the rural west Elgin community and is worthy of consideration when attempting this kind of coordinated service in a school setting.

Of probably greater concern to our committee, though, is earlier intervention and provision of appropriate supports, which we believe would be well-placed in schools to avoid disruption for the students and decrease stigma in the community. This could be accomplished in an itinerant way for smaller schools or by having centres of service in larger schools or in high-risk areas.

We have enjoyed a partnership with the London Learning Clinic, which had medical staff on site at Lorne Avenue Public School in London to diagnose and treat conditions such as ADHD, ADD and anxiety disorders, which impair a student's ability to function in class. Their report of activity for the 2007 school year identifies the numbers of students served by a single physician in a one-year period. This partnership ends at the end of June because of issues with sustainable funding. The clinic was initially served by seven physicians, and in spite of overwhelming need, the physician who remained was unable to bill for much of the time required to provide the service and was unable to recruit assistance or a replacement under those conditions. Again, in this partnership, our board provided the site at the school and in the past year helped with funding as well.

Additionally, the Southwest Ontario Aboriginal Health Access Centre has been attempting to bring a fetal alcohol spectrum disorder diagnostic clinic to the area in order to better identify that neurodevelopmental disorder. FASD affects at least 1% of the general population, and secondary mental health conditions occur in over 90% of affected individuals. It is extremely difficult to access assessment and service locally. The board has recently facilitated a cross-sector networking group for FASD, but provincial support and direction is urgently needed to catch up with supports and services available in other jurisdictions.

If improved health and mental health screening and assessments were available on-site, earlier identification and provision of appropriate services would prevent many maladaptive behaviours and secondary conditions and improve outcomes for children suffering from untreated mental health conditions. When you look at the

characteristics of various mental health conditions—and you've got that sheet as well—it is obvious that the children will have difficulty in a school environment if not appropriately assessed and treated. The school-as-hub model would significantly improve assessment and treatment opportunities and hopefully reduce disrupted school experiences with a view to improving life outcomes for all students.

In order to facilitate a school-as-hub model, there are many barriers which have to be addressed. Access to information needs to be coordinated and labour issues addressed. Questions about the funding for support staff needs of a combined or shared staff of professionals and allowance for removing vacant space costs for school boards need to be answered. Funding streams should be coordinated to allow professionals to straddle various sectors in serving individuals. The student support leadership initiative is off to a good start in looking at the logistics of consumer-centred services, but some ministry-level changes will be needed to make a true co-operative service model a reality.

Thank you very much for your consideration of our issues.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Cathy, Tracy and Deb. Your presentation was well received and was paced well, but unfortunately there is no time for questions, and we are going to move on to the next delegation. But thank you very much for coming today.

CANADIAN HEARING SOCIETY

The Chair (Mr. Kevin Daniel Flynn): For our next delegation, we're going to change things around a little bit. We've got the Canadian Hearing Society next, and we're just going to make a few alterations before that begins. Now, do you want your mic live all the time? Okay.

Thank you very much for coming today. We're learning as we go along, so it's been a learning experience for us all. We have your printed presentation before us, and we're ready to hear from you.

Ms. Karen Frayn: Thank you very much. My name is Karen Frayn, and I'm the director of Connect Counselling Services at the Canadian Hearing Society. You have had a live, lived lesson this afternoon in accessibility, as you saw that the last two presentations were quite inaccessible at times for deaf participants in the audience, and I say that not to blame or criticize anyone. This is a group of committed, high-functioning, dedicated, interested people who want to exchange information. Your audience, your presenters, are sophisticated, high-functioning mental health professionals and consumers who want to exchange information, and nonetheless, it was very challenging to make it accessible with three sign language interpreters.

Now, imagine that you are a psychotic deaf person who doesn't know anything about the system, is short on information, has compromised language skills; you're a

signing deaf person, and you go into the local emergency department where the hearing emergency doctor has never seen a signing deaf person before in his life, has a lineup of people waiting to see him—imagine what access is going to be like for that deaf person. It's going to be non-existent, not to mention the fact that the deaf person is probably clogging up that emergency department unnecessarily; they could be served better elsewhere—cheaper, faster and more effectively.

My colleague Gail Brunsdon and I are here today to talk about the fact that there are a quarter of a million Ontarians who have both a significant hearing loss and a significant mental health or addiction issue, and because their hearing loss is so significant, our consumers cannot access mainstream mental health and addiction services. It is not a matter of how long they have to sit on a waiting list. I worked most of my career, before I came to the Canadian Hearing Society, in mainstream mental health services; I know how short of resources they all are. I know nobody has enough funding; everyone has waiting lists. But I listened to our fellow presenters today with envy, frankly, because they can talk about their waiting lists. Our consumers can't sit on a waiting list somewhere. They don't have a choice of which waiting list to sit on. There simply are no services apart from Connect, our program. We are the only mental health and addiction services in Ontario for deaf and hard-of-hearing consumers.

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Deaf and hard-of-hearing people are denied access to mental health and addiction services in Ontario, in violation of their charter rights. For those of you in the room who are MPPs, I can guarantee that you all represent deaf and hard-of-hearing constituents in your ridings who cannot get service in your ridings. They cannot get service anywhere in the province of Ontario. You would be astonished at how many service providers simply say, "I'm sorry, we don't serve deaf."

Connect is a provincial program. We are managed provincially by corporate MOH as a provincially managed program. It's the only mental health and addiction program in the province for deaf, deafened and hard-of-hearing consumers. We're funded at slightly under \$3 million annually and we're mandated by the Ministry of Health to provide a comprehensive network of services across the entire province: direct service and service partnerships from Hudson Bay to Windsor to Kenora. We have approximately 30 staff spread out across all regions of the province and more than 50% of our staff are consumers. They are deaf, deafened or hard-of-hearing themselves. We are mandated to be an entry point into the mental health and addiction service system in Ontario for our consumers. We provide direct access, if that's the consumer's choice, because we are a fully accessible environment. We can operate in the language and culture of the consumer. We have signing staff, we have interpreters, we have real-time captionists. A captionist is like a court reporter, who takes down verbatim everything that's said in a meeting and flashes it up on a screen so

that if I turn deaf tomorrow, I can see what you just said on the screen. And we have a host of technical devices that are designed to facilitate access.

We are also mandated to do outreach to consumer communities and to mainstream service organizations like those that were here today. We're mandated to partner with them so that they can provide accessible and appropriate services for deaf and hard-of-hearing consumers. Many deaf people would do almost anything to avoid being in the hospital. For a deaf person to be in a mainstream, hearing hospital environment is very isolating and very frightening.

I'm going to turn it over to Gail now and ask her to speak about some of the specific challenges that we encounter in trying to get service for our consumers. I was just telling Gail, because she's going to stand, I'm going to hold the notes in front of her and she can either have me stand beside her and my hands will shake and her notes will shake, or I will sit in front of her and hopefully my hands will shake less. So if we play around a bit with access here for a minute, you'll understand.

Ms. Gail Brunston (Interpretation): Okay. Thank you, Karen. My name is Gail Brunston. I work as a support worker for the deaf community. I am nervous myself but I would like to thank you all for the opportunity to come here and present for you in my native language. It's a good experience for me and a first-time experience for me.

I'm not really sure where I should start but I'd like to explain my role as a front-line worker. I have direct service with deaf clients. I work out of the Canadian Hearing Society office. I just want to let you know I was born here in this community of St. Thomas. I've lived half my life in London, but I was born and raised here, so I know a few of your faces and who you are. It's nice to see you.

My personal experiences: I have suffered from physical abuse myself. My uncle was in the psychiatric hospital in St. Thomas for many years, about 30 years, and he died a few years ago. There have been lots of things in my life that have really impacted it. I've had four children. In all four of my births, I experienced depression afterwards. I didn't really understand depression; I didn't know what it looked like. Nobody taught me what to do or what I could do about it. I would go to a doctor and just say, "I feel sad and frustrated," and the doctor would say, "Here, take these pills." There was no understanding and no explanation as a deaf person. At the time, there were no interpreters available for service. I was written some notes by the doctor with vocabulary that was above my understanding. That definitely was a gap in communication. Those kinds of things happened my whole life.

The result of that has made me more motivated today to work for my clients. That's why I like to motivate my deaf clients and work with the deaf community. I've studied mental health for a number of years. I know where the gaps in service are. There are many specifically for deaf clients.

My role as a front-line worker is twofold. First of all, as an educator, I'm involved in community education, and it's not just about mental health and wellness; it's also about other illnesses as well, addictions, that type of information that I try to teach the community. Plus I'm involved with the families—maybe it's deaf parents who have hearing children, or hearing parents who have deaf children—just trying to educate what that actually means, deaf culture, the deaf experience. I travel a lot. I do presentations, and I've been doing them for over 25 years, so I've seen a number of gaps in service.

The two biggest barriers for deaf people with mental health issues are the lack of understanding about deaf culture—there is very little understanding—and accessibility, communication accessibility. There are lots of mainstream service providers, but they don't understand the communication issues. We've had problems with the police but also with the hospitals, and I've seen it firsthand.

I like to teach different service agencies that are already there. They deal with hearing clients. I've been involved with Alcoholics Anonymous programs in teaching accessibility for deaf people. I also try to train people on what to do if a deaf client does come in. I try to teach them how to make the environment accessible for a deaf consumer. That takes a lot of my work.

Across Ontario there are six people who have my role, so can you imagine servicing this many deaf people with mental health problems in Ontario? It's too much work for just the six of us.

I just want to keep looking for the interpreter to make sure she's keeping up and understanding.

There are four major challenges that we've seen over and over again for deaf consumers.

It's happened lots of times, and this has been over the past 50 years: Deaf consumers have been put into a psychiatric hospital, left there, given a diagnosis and left institutionalized, and really it was the wrong diagnosis. The problem was that there was no interpreter available; there was no communication access. Maybe these people were prescribed the wrong medication. There was just a lack of understanding of what was actually wrong with this person because there was no communication access. It's had a huge impact on the deaf community.

When that person, that consumer, finally leaves the hospital, they are then put out into the community with very little support. They are awkward. They don't know the world; they don't know how to communicate with people. That's where the Canadian Hearing Society likes to step in. We can communicate with them; we speak the same language. So that means we can form a partnership with these hospitals, and it has to happen. We have to figure out what our role is and what the institution's role is so we can work for the best for the consumers.

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Also with addiction programs, with how many beds are available, or the day treatment programs or residential programs—it doesn't matter whether it's a day program or a residential program; the problem is that the service

care providers don't know how to provide care for this person. The staff is often screaming for help, and they're left writing notes back and forth. This is not adequate treatment. Lots of times a deaf consumer is dealing with their second language as English, and written notes back and forth are not going to provide the treatment they need. Too many misunderstandings occur. So there are no addiction treatment programs in Ontario for deaf clients.

If a deaf client does have serious mental health issues, sometimes they're not diagnosed properly. Sometimes they might go to one place and they'll say they're depressed, and then they'll go to another place without an interpreter—and so it could be any of a number of issues. Sometimes they won't make an appointment or won't book an interpreter, or sometimes the care provider doesn't understand deaf access. It's rare that a service provider actually understands what they're dealing with when they do come into contact with a deaf consumer.

Treatment and addictions programs—there are none in Ontario. There is one, but it's in the United States, in Minnesota. That's a special program for addictions for deaf consumers. It's a 28-day program, with residential care, but in Canada there is no service, no program.

We have one client, a man who's 45 years old. He had trauma when he was young—he was abused—so a number of problems and huge communication issues. His family didn't even sign with him, so he is completely language-deprived. He detached and had a number of problems growing up. He became angry and had anger problems. He came for some help, but I wasn't able to give it to him because of the lack of service in Ontario. He was in and out of jail a number of times, with still no support for him. So when they called the Canadian Hearing Society and the Connect program specifically to try to go in to support him, I was not allowed to support him in court because I wasn't allowed to have an interpreter, and the whole process went off the rails. So servicing somebody like this is next to impossible. His lawyer didn't even understand deaf issues, the person who was supposed to be representing him. The lawyer didn't even understand how to hire an interpreter. So this person ended up being remanded for a longer period of time—until the court booked an interpreter, because they couldn't find an interpreter—and it was just an awful experience. There were no interpreters available and they didn't know how to book an interpreter. This was an incredible challenge for us. We were so frustrated, and the compassion we felt for this man was unbelievable. He tried to kill himself; he was depressed because he just couldn't get help anywhere. And this is just one isolated situation.

I've been working with him one on one trying to support him. He's still in treatment for addiction, but he doesn't have an appropriate program. The hearing programs will offer him, you know, "Come to an AA meeting. That's going to be a good place for you to be. There are people there and there's communication there and you can stand up and say, 'My name is so-and-so and

I am an addict.'" But for a deaf person to go into that situation is impossible, because he has to book an interpreter, and sometimes it's a two- to three-week wait before an interpreter's actually available. Then they finally get an interpreter available, and to go into that meeting is a different experience for a deaf person. Sometimes the meetings will be booked or counselling will be booked and the client himself will not go because he's tired or fed up. So sometimes the interpreter will show up and not have a client there. We're trying to provide access in some situations and sometimes that's not successful. This client is a really big challenge for us at Connect.

As well, this man doesn't want to go into the peer meeting; he's not comfortable there. The problem is, it's a hearing group, and he doesn't feel that he's getting access. The conversation happens too quickly, even with an interpreter. One interpreter has a hard time managing 20 people in that group. It's impossible for the information to be conveyed accurately, so he doesn't feel that he can convey his experiences or the trauma that he has experienced growing up. He doesn't want to attend that group. It's a huge challenge.

A third point I'd like to make is that deaf people who have mental health issues worry about the stigma—sorry, they have a misdiagnosis. Often what happens is they're assessed without an interpreter and a diagnosis is labelled to them without proper communication. So what we do at Connect is go with the client, make sure the communication access is adhered to and make sure the information is clearly presented to make sure we have an appropriate and accurate diagnosis.

This point, the third point, is really a complicated issue. Sometimes the client is deaf and doesn't just require one interpreter; they might need a second interpreter, who's called a "deaf interpreter." Because of their language delay—sometimes the person's language is delayed and a hearing interpreter may not understand them, so we hire a deaf interpreter to interpret from this deaf client's language into American Sign Language, and the hearing interpreter can then convey the message from American Sign Language to English. There are lots of complications about linguistics with some of our clients, and we try our best to avoid a misdiagnosis. So communication access is of huge importance.

My fourth point is mainstream services providing access. Clearly there are lots of services available. Connect has tried to partner with many of those services and tried to see if our clients could be a fit for therapy, whether it's day treatment, addiction programs or residential care. Often what we're met with is a fear: "We can't provide service for your clients." They have to follow their own policies; their policies don't provide access. So it's frustrating for us when we're trying to develop those partnerships. We're willing to train these staff and train these agencies on what to do. We often get rejected; it has happened to us many times. So the struggle continues for us—and, really, when I say "afraid of us" or "fear," it's a lack of understanding. They need some education so they're able to deal with deaf clients.

I think another problem is that people don't want to spend the money for the access; they have no time for that and no resources for that. Sometimes we do have funding available for interpretation, but the agencies do not want to forfeit their own. We don't mind paying for the interpretation services if these agencies don't have the budget for it.

In meeting with all of you today, my hope is to have some sort of a treatment program for deaf in addictions in Ontario. There are a high number of deaf individuals who do have addiction problems that lead to mental health problems that need treatment.

We have staff who know the language in ASL. It would be nice if they could be hired. I mean, in a deaf world, it would be nice if they had somebody who's deaf as well to communicate with them in their first language, especially when they're dealing with something as dramatic as mental health issues.

The program in Minnesota is willing to come and train us, train our staff and educate us on what they do. When I saw their presentation, I just felt it was a perfect fit for us and our consumers and what we need. I really do wish that we could set something up here in Ontario.

That's it for me. Thank you, and I'll save it for the question period.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much. Thank you, Gail and Karen.

Gail, could we get that information sent to us from Minnesota or could you arrange to have it sent to us?

Ms. Gail Brunson (Interpreter): I sure can. I certainly will.

The Chair (Mr. Kevin Daniel Flynn): Wonderful. Thank you. If you could send it to the committee clerk, that would really be appreciated.

Ms. Gail Brunson (Interpreter): I'd be happy to do that.

The Chair (Mr. Kevin Daniel Flynn): Thank you. Karen?

Ms. Karen Frayn: I just have a few wrap-up comments, but I want to check on how we're doing on our time before I move ahead—

The Chair (Mr. Kevin Daniel Flynn): Oh, I think the time has kind of gone out the window a little bit, so why don't you just do your wrap-up. We have to be on a bus at 4:30, so if you just—

Ms. Karen Frayn: And is the bus coming right here to give you door-to-door service?

The Chair (Mr. Kevin Daniel Flynn): The bus probably is here, so if you could do your summary, that would be great. I believe our bags are on the bus already.

Ms. Karen Frayn: All right. We could have done this presentation at any one of your stops around the province because ours is a provincial program and a provincial message. We have been very effective as a provincial consultation liaison program. We employ best practices. We have 90% positive outcomes, which is unheard of in the mainstream mental health field. Both our program

and the Ministry of Health have been publicly cited for very innovative use of funding to give access to a group of consumers who were formerly shut out of the system.

We cannot possibly serve a quarter of a million people from Hudson Bay to Windsor and from Kenora to Ottawa on \$3 million a year. We don't need an entire bailout package for a whole industry, but we do need some decent level of funding. I would ask all of you to ask yourselves why a specific disability group of a quarter of a million Ontarians is shut out of the system in Ontario. For any of you who have anybody in your family or your friends who is different, who has special needs, who has a disability, how would you react if you were to take your son, your daughter, your sister or your mother to a mental health service provider and have them tell you, "I'm sorry, we don't serve people who are blind. We don't serve people who are in wheelchairs. We don't serve people who have cerebral palsy. We don't serve deaf people?"

Please help us. This is unconscionable. We do our work because we can make a difference, and we do make a difference. For consumers who have never had access to service, when they get it, the changes are dramatic.

The Chair (Mr. Kevin Daniel Flynn): I think you've made your point very well, both you and Gail, and I think the point was understood by all members of the committee. I have a feeling they'll remember this presentation. Thank you very much for coming today.

M^{me} France Gélinas: One quick question.

The Chair (Mr. Kevin Daniel Flynn): Okay.

M^{me} France Gélinas: I have a number of francophone deaf in my riding who use QSL. Is your service available in QSL?

Ms. Karen Frayn: The agency as a whole—LSQ?

M^{me} France Gélinas: Sorry, I used the French; yes, LSQ.

Ms. Karen Frayn: It's all right. LSQ refers to langue des signes québécoise. Pardon my pronunciation, Madame Gélinas. We are working as an agency, and as a program in particular, to develop our services in LSQ, which is the French equivalent of ASL. Your riding is one of two in the province, being Sudbury and Ottawa, where we have LSQ interpreters on staff. It's great that we have LSQ interpreters. That means, of course, that the consumers then demand that we provide them the service, and so we are working very hard to build our capacity to do that. But really, in order to fulfill our mandate under the charter as an agency—and we are a French services designated agency in most regions of the province—we should be able to provide our services in four languages: in ASL, in LSQ, in French and in English.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today.

That's the end of our deliberations for the entire day, so we're adjourned to Hamilton.

The committee adjourned at 1623.

SELECT COMMITTEE ON MENTAL HEALTH AND ADDICTIONS

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ISSN 1918-9613

**Legislative Assembly
of Ontario**

First Session, 39th Parliament

**Assemblée législative
de l'Ontario**

Première session, 39^e législature

**Official Report
of Debates
(Hansard)**

Wednesday 17 June 2009

**Journal
des débats
(Hansard)**

Mercredi 17 juin 2009

**Select Committee on
Mental Health and Addictions**

**Mental Health
and Addictions Strategy**

**Comité spécial de la santé
mentale et des dépendances**

**Stratégie sur la santé mentale et
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Hansard Reporting and Interpretation Services
Room 500, West Wing, Legislative Building
111 Wellesley Street West, Queen's Park
Toronto ON M7A 1A2
Telephone 416-325-7400; fax 416-325-7430
Published by the Legislative Assembly of Ontario



Service du Journal des débats et d'interprétation
Salle 500, aile ouest, Édifice du Parlement
111, rue Wellesley ouest, Queen's Park
Toronto ON M7A 1A2
Téléphone, 416-325-7400; télécopieur, 416-325-7430
Publié par l'Assemblée législative de l'Ontario

LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

SELECT COMMITTEE ON
MENTAL HEALTH AND ADDICTIONSCOMITÉ SPÉCIAL DE LA SANTÉ
MENTALE ET DES DÉPENDANCES

Wednesday 17 June 2009

Mercredi 17 juin 2009

The committee met at 0901 in the Sheraton Hamilton Hotel, Hamilton.

MENTAL HEALTH
AND ADDICTIONS STRATEGY
MENTAL HEALTH RIGHTS COALITION

The Chair (Mr. Kevin Daniel Flynn): Okay, if I could ask the members to begin taking their seats, we can get started by calling forth the first delegation, the Mental Health Rights Coalition, Frances Jewell. Frances, if you'd like to come forward to the end of the table. Make yourself comfortable; pour yourself a glass of water, if you'd like.

As we travel across Ontario, everybody is being given 20 minutes, so you can use that any way you see fit. If you could leave some time at the end of the presentation for any questions and answers, that would be good, but it's not necessary. Apparently, the mikes work better when you're about a foot away from them. Other than that, the time is yours, and welcome.

Ms. Frances Jewell: Thanks very much. I'm delighted to be here this morning. My name is Frances Jewell. I'm the executive director with Mental Health Rights Coalition here in Hamilton. I'm also very happy to be the first presenter, hoping that you'll be nice and fresh. I'm sure that by the end of the day it's an awful lot of information for you. I did bring a PowerPoint presentation; however, I brought a memory stick, and wasn't advised to bring a computer. So I'll have you refer to this; it's probably easier on your eyes.

Again, I work for the Mental Health Rights Coalition here in Hamilton, and we are a consumer-survivor initiative, also known as a CSI. That CSI is not "crime scene investigation"; it is consumer-survivor initiative. Perhaps you've already heard that term. The Mental Health Rights Coalition has been, I believe, incorporated since 1991. Our goals are to reduce stigma, reduce isolation, increase accessibility, support integration and promote participation.

And what do we have? We provide peer support. That means that our operation is run by peers for peers, by people with mental illness for people with mental illness. We provide direct peer support for people. A person can drop in to see us; they can give us a telephone call and receive counselling, support, help with finding transportation—all kinds of different things. We are also the only

CSI in the area that provides training for peer support workers. St. Joseph's Healthcare here in Hamilton has made it policy that all of their peer support workers are trained by us at Mental Health Rights Coalition. We have a drop-in centre, we have various committees, volunteer opportunities, jobs available as well—job postings, etc.

Still on page 1, under stats, we had 3,765 individual visits for a total of 5,671.7 hours with 2.8 full-time employees, and my budget—please note the budget—is \$133,000, shockingly low.

If you go to page 2, what is peer support? I've touched on that already. Peer support means that a peer provides support, and through various studies it has been proven that a person with mental illness likes to connect with someone else who has experienced mental illness. Again, we have a drop-in centre. We're open Monday to Friday, 11 till 4. How will peer support help? It gives people exactly that: support within the community and a connection with someone else who has experienced perhaps the system, perhaps recovery—all of those things.

Community partners: We are in partnership with a number of people in the Hamilton area. We are part of the Hamilton Addictions and Mental Health Network. You'll see a number of people listed there: COAST, CAMH, St. Joe's and Good Shepherd.

The rest of the PowerPoint really talks about some statements that recently came up from people who have experienced mental illness. We ran some focus groups to gather some information to report back to the LHIN and the Ministry of Health. You'll see a number of quotes here, and I would like to read them to you because I find that they are pertinent to today.

The first one is: "If I had cancer there, I would be treated with respect. But I have depression so the government does not care about me."

"I want you to know that mental illness is a major part of today's society."

"Illness is not the enemy ... ignorance is."

"We are all gifts from God. It doesn't matter how sick we are, we are special."

"Mental illness ... make it go away? I can't make it go away."

"Get to work and provide funding to help us recover."

"I want the government to provide money to those of us with mental illness so we will have a better standard of living beyond subsistence."

"I would like to have more fun activities on the weekend so I don't feel so alone."

"Empower diversity. Help me get well."

"Please increase the funding for mental health services and also reduce stigma issues for us."

"I need you to listen."

"How many more times will the government ask us what they can do to help before they actually do something? How many more people will die from mental illness?"

"A peer worker in every emergency room in the province."

"Don't stigmatize mental health consumers. Give them adequate support."

"We need more money for seniors with mental illness."

"We need a peer support worker in every emergency room in Ontario."

"Don't stigmatize people with mental illness. Give people adequate financial support."

"Peers (who are experts in mental illness) need to be involved in all aspects of a person's recovery and paid accordingly."

"I deserve the opportunity to recover from mental illness as much as I would from cancer."

"Peers who are experts in mental illness need to be involved in all aspects of recovery and paid accordingly." I apologize; I think that was a repeat.

So that's my presentation in a nutshell, and I would like to ask you if you have any questions.

The Chair (Mr. Kevin Daniel Flynn): That's great. You left a lot of time for questions, so we'll sort of rotate it and start with France.

M^{me} France Gélinas: Good morning. I'll start by apologizing for missing a part of your presentation. I came with short sleeves, and it was way too cold in here to stay with short sleeves so I had to run back.

I had a chance to read through the slides that I missed. When you talk about peer support, are you putting the focus mainly on mental health survivors or are you putting it more broadly to include families of people who have lived with mental illness etc.?

Ms. Frances Jewell: Peer support, where I am, is geared to people with mental illness. However, we do have family members who come in to access information, and they often identify that they are in need of peer support. So we certainly wouldn't send someone away. We also have people who come in with addictions issues, but again, we are not an addictions-focused group; we are more mental health and mental illness. But people will come in and ask for assistance.

M^{me} France Gélinas: I don't know if I missed it, and if I did, I apologize again, but can you explain a little bit to me what peer support would do and also what they don't do?

Ms. Frances Jewell: Certainly. For instance, if you're a physician, your peer is another physician. With our agency, a peer is someone with lived experience of mental illness. We provide training for peers, for people who have experienced mental illness, to become peer support workers. So a peer support worker could provide

anything from one-on-one counselling to helping a person navigate a computer system to finding, perhaps, affordable housing or transportation. They would do many things.

0910

M^{me} France Gélinas: You said you don't turn anybody away. But it would be mainly people who have a diagnosis of mental illness?

Ms. Frances Jewell: We're not interested in whether they're diagnosed with mental illness. They come in. A person would identify themselves as having mental illness, but we don't talk about diagnosis and we don't talk about medication. Sometimes medication would come up, but we certainly don't advise on medication or whatnot.

M^{me} France Gélinas: Does your agency do any work in what I would describe as health promotion or illness prevention?

Ms. Frances Jewell: With a budget of \$133,000, no.

M^{me} France Gélinas: You focus your attention?

Ms. Frances Jewell: We certainly try to model healthy behaviour. I would be delighted to do something on health promotion, absolutely delighted to do that. But with a budget of \$133,000, there is no budget for that. There's no room for that.

M^{me} France Gélinas: Okay. Let's say a francophone person comes to your agency. Are you able to meet their linguistic needs?

Ms. Frances Jewell: No. We do have someone who speaks Spanish, but I don't have a French-speaking staff member. Again, I would be delighted to have resources to afford to hire an additional person. That would be wonderful.

M^{me} France Gélinas: Where does your funding come from?

Ms. Frances Jewell: The Ministry of Health, LHIN 4.

M^{me} France Gélinas: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you, France. Helena?

Ms. Helena Jaczek: Thank you for your presentation. You're actually reinforcing some of the issues that we've heard already. In fact, we heard peer support referred to as peer navigators, which I really liked, giving that sense of helping people navigate their way through the system.

I have a question about the funding as well. Would you have also received, then, a Trillium Foundation grant?

Ms. Frances Jewell: We did for peer support training. That's actually how we developed the peer support training program. So the Ministry of Health doesn't actually pay for that; we paid for that through Trillium.

Ms. Helena Jaczek: If you had more funding—obviously, you've said no wait time. What would you do with more funding? There was the comment from one of the survivors related to activities on weekends. What would you do if you did receive more funding?

Ms. Frances Jewell: I would do a number of things; one of them would be to put myself in a building that was secure, safe and appealing. Again, my budget is so small that I'm in a building that's not really suitable. I don't

have wheelchair access, and I've tried to accommodate that. I do accommodate that in some way, but with some difficulty.

I would probably expand my hours. Again, we're open 11 to 4. That's midday. Many people who come to visit us live in second-level lodging, so at 9 o'clock, after they've received their breakfast, they are given a little brown bag with maybe a 99-cent horrible—you know, those dried noodles—and often they're told, "Don't come back until dinner." So people come in to see us. I would like to provide all kinds of groups for people to attend, whether it be—I'm not even really sure. I don't know that resumé writing is what people want, but they're looking for additional training in all types of things. I would provide training, I would expand my hours and I would put us into a safe, clean, welcoming environment. People with mental illness are often going to substandard locations for services.

The Chair (Mr. Kevin Daniel Flynn): Thank you. Any other questions from that side? Maria?

Mrs. Maria Van Bommel: Please. You left us with this as well.

Ms. Frances Jewell: Yes.

Mrs. Maria Van Bommel: If you could explain what—I'm just reading through the foreword. That's about as far as I got before we got started.

Ms. Frances Jewell: Certainly. The peer primer was part of a Trillium Fund project with the Hamilton Program for Schizophrenia. With that project, we trained peer support workers and seconded them to mainstream agencies throughout Hamilton with great success. So we're very pleased.

Mrs. Maria Van Bommel: What types of agencies did you place them in?

Ms. Frances Jewell: The Hamilton Program for Schizophrenia, St. Joseph's hospital—sorry, they call themselves St. Joseph's Healthcare now—WPOP, the Canadian Mental Health Association. We had tremendous feedback from that. Part of the peer support primer was also an art project, and that was—

Mrs. Maria Van Bommel: Yes. I saw the art pieces in the back.

Ms. Frances Jewell: There were a few people who received colour photocopies of that. I thought there were five people showing up today, so there were five colour and the rest are black and white. But if you get a chance to see the colour—

Mrs. Maria Van Bommel: Even in black and white, they're quite impressive.

Ms. Frances Jewell: So the art program was part of the recovery program as well. That would be something I would love to see us connect with as well. We have a very big arts community here in Hamilton, and I would like to see the art program expanded into mental health and mental illness and recovery.

Mrs. Maria Van Bommel: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you. Sylvia?

Ms. Sylvia Jones: Thank you. Good morning. When you talk about peer support, with your 2.8 full-time equivalents, are your staff training the peer support workers? Tell me more about the process. Is it one on one? Is it group peer support? Because I see on page 16, where you talk about a brief history, that you mention support groups, but I'm not sure if that's directly related to what you're doing or just generally.

Ms. Frances Jewell: Well, we do run support groups at our centre. However—

Ms. Sylvia Jones: And that would be in that 11-till-4—

Ms. Frances Jewell: Yes, that's right. However, the training part of it—if a person identifies that they're interested in becoming a peer support worker, they would come in to see us. We interview them and make sure that they're a suitable candidate in many different ways. We try to run three training sessions per year. They are 12-week training programs and they are offered free to people, to the potential peer support worker.

Ms. Sylvia Jones: In that 12-week period, how many hours of training would you give before that peer support worker would be ready to go out and assist?

Ms. Frances Jewell: It's 24; however, they don't just simply go out and assist then. We ask them to do practicum, hands-on hours. We ask them to do that within our agency, if possible, and if not, then we certainly would support them if they told us that they were doing a practicum for someone else, for another agency. We would say, "Absolutely, we support that." They then come back for a final interview, and they're graded and passed. Certainly, not everyone is suitable as a peer support worker.

Ms. Sylvia Jones: Do you keep in contact throughout the subsequent months or years, in terms of upgrading, touching base? What kind of support does the peer worker have?

Ms. Frances Jewell: That's a good question, because peer workers often do have a lot of stress or burnout when they go into mainstream agencies. We invite them back several times a year, not necessarily for training but more of a support—a debriefing.

If we could train all of the peer workers in Hamilton and second them out to programs, to other agencies, that would be ideal, because we do have a concern that what happens is, when peers go to work for mainstream agencies they lose the peer focus and they become much more of the agency focus, which, in our opinion, doesn't support recovery in the same type of way.

Ms. Sylvia Jones: Okay. One final question, and this comes from—we're in the third day of our committee travelling. We are hearing more and more about people who have a dual diagnosis: They have a mental health issue but they also have an addiction—whatever starts first; it doesn't really matter. And yet, at the beginning of your presentation, you mentioned that it's challenging for your organization to deal with the double.

Ms. Frances Jewell: Well, I think that, really, it has been very much a separate issue—or not that it is a

separate issue; it's not. But it has been sort of played out as a separate issue—addictions over here; mental health over here—and it is not the case. We're very interested in collaboration and we do work with other agencies that have more addictions experience. For instance, there's a fellow in town who runs a number of houses here and he has suggested that he would like to hook up with us in some way to really promote the mental health and addictions piece. It's really a traditional thing. It's been more mental health, but without a doubt we have many people who have addictions problems, all types of things. We're aware of that. Again, it comes down to funding for many of us.

Ms. Sylvia Jones: Sure. Do I have time for one more question?

The Chair (Mr. Kevin Daniel Flynn): Unfortunately, you don't. Thank you, Sylvia, though, anyway. And thank you for coming today, Frances. We really appreciated that.

0920

RAISING OUR CHILDREN'S KIDS

The Chair (Mr. Kevin Daniel Flynn): Our next delegation this morning is Barbara LaFleshe from Raising Our Children's Kids. Barbara, if you'd come forward.

Interjection.

The Chair (Mr. Kevin Daniel Flynn): Okay, there are four of you. We have four seats and four microphones. This will all work out. Now, the thing is, when you do speak—is somebody listening? Yes. When you do speak, you need to identify yourself for Hansard so they'll know which one of you is speaking. So before you speak, if you would identify yourself, that would be great.

Like everybody we've seen before us, you have 20 minutes. You can use that any way you see fit. It is better, we've found, if there is some time left over at the end, but it's not necessary. You don't have to do that if you don't want to. You can use the whole 20 minutes yourself if you want to.

Having said that, the time is all yours.

Ms. Barbara LaFleshe: Good morning. My name is Barbara LaFleshe and I'm with a group called ROCK Canada. We are located here in Hamilton. We're a support group. The name ROCK is Raising Our Children's Kids.

To my right is Beverly McIntosh, who will be talking on the fetal alcohol syndrome story. Next to her is Christine Joseph-Davies, a grandmother with our group who is raising a grandchild who has autism. On the end is Diane Chiarelli, our president, who is going to introduce the double-decker sort of phase of our lives, where she is raising her child and her grandchildren and is looking after her extended family.

Just to start off, I could tell you a huge, long story about my daughter and her mental health situation. We thought she was just a rebellious child. I have four

children, so I figured one of them would give me a run for my money. Initially, I thought she was just a hippie child, because she was into the environment and all of this, but it went on further. Her life was just chaotic. She was just running from thing to thing to thing. I was trying to keep up, take her to doctors' appointments.

Literally, I found out that at that range, at 16 years old, family physicians will not give you any information about your child without that child's permission. Then, when it led to her trying to take her life, which she did try to do four different times, it was so severe that she had a security guard at the foot of her bed for days on end. She was placed in bubble rooms. She's run away from the hospitals and been pulled out of our house and thrown on the front lawn with a policeman's knee right in her back. She has been handcuffed and put in police cars and taken back to hospitals.

Literally, I realized at that point—because we were proving that we were parents who cared about this person, this child of ours, this sister—we could not get information because of patient rights. It was at one point a social worker for the city of Hamilton told our family that they were going to place her in a lodging home and that they were going to help her. What really happened was that she was placed in a lodging home, and a lot of the lodging homes in this city are privately owned and run. A lot of money is being made by private entrepreneurs. They're not fed well but there is a cook who does care, and she is the cleaner, she doles out the medication. Yes, you do see the owners sometimes, but they're not in the picture, and there is no pressure on these people to participate in any programming to help them recover.

Literally, they visit other members of the psychiatric community in various lodging homes. This is where she met up with the father of my grandchild. He was out of the jail system, and no doubt he has mental illness as well.

It's from 16 years up to 88, even street people; there was an 88-year-old woman in the same lodging home. No locked doors; men and women together, using the same bathrooms. It's just a free-for-all. It wasn't just one lodging home; I've been in many.

She brought many people to me to help or give lunch or a few dollars to. It was just an ongoing, chaotic, horrendous situation that our family has endured. But out of that came our granddaughter, and she actually—my daughter is very clever. I was told by a psychologist that she's retarded, and I said, "That's impossible." She's very manipulative at the same time, and was smart enough to get a midwife and actually have the baby come right to my apartment, that I was going to help her raise this child. But within 10 months, she became very ill again and went back into the hospital.

She has introduced three different men as fathers to my granddaughter—the biological father, the chosen father and the new father. Literally, all of these people are on ODSP and have mental problems themselves. But it's her lack of choices that has caused us a great deal of stress and concern.

We're coming to you because we're now raising grandchildren in this story. We've had difficulty with the custody stories. On ODSP they have free legal aid, and they are taking us down financially as well. We need intervention. We need our government to know that there are caring parents out there. We need parents' rights in the situation of raising these children, as well as grandparents' rights.

I'll introduce Bev McIntosh.

Ms. Beverly McIntosh: I'm a grandmother of two fetal alcohol children. Rosina was nine months old when I got her. She was born in Toronto. I didn't even know that she had been born until children's aid called me and wanted to talk to me because the mother couldn't handle her. She was also two pounds when she was born and was in the hospital for four months. She has had major problems since she was a baby. She had problems drinking, swallowing Pabulum. She wasn't on food until she was two years old. It was just Pabulum and milk and vitamins to try and keep her up, because she just couldn't chew; she couldn't eat. Now she can eat, but she's still very picky—very small, soft stuff. She doesn't like anything hard still.

But she has many, many problems other than that as well. She's developmentally delayed by three years. In school she's in grade 4 but she's doing grade 2 work in grade 4 because she can't handle any higher. Each year she moves up. It depends. She might still be in grade 2 next year when she moves up.

Besides that, she is a very volatile child now. She's 10. She just gets very angry and she'll kick somebody or bite them. She gets very, very violent when she gets angry. It's because if she can't sit down and play her videogame or she can't watch the TV—"You've got to do some homework"—she just blows up. Other times, she just blows up for no reason at all. She just picks on me because I'm her parent per se, even though I'm her grandmother. She actually misses out on a grandparent because I can't be a grandparent either. I have to be the one that has to tell her, "You've got to do this," you know?

She's a beautiful little girl, although she's tiny. She's only 42 pounds and she's 10. But she's never going to be very big because of the—her fetal alcohol is more severe than her brother's because the mother drank at the beginning. She has the features and is very developmentally delayed.

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Now, when Austin was born, the mother had moved to Hamilton. He was born and taken to McMaster to have his hair tested, and he had alcohol in his hair follicles, although the mother, to this day, says that she didn't drink. He doesn't have the full one; he has the behaviours, and he can't control his behaviours either. So when the two of them get together, it's like a fighting match in a ring sometimes, and I have to get in between and separate them.

He, right now, is going through a large problem. The school called me, and I went in to see this picture: It has

a bat on this wall, and the story was that the bat came in the house, the father took a knife and stabbed the bat, and the blood's running down on the wall, and then he chased the kids out.

So he's now back in Lynwood Hall. This is his second time to go up there. The lady's coming tomorrow to talk to me and see what we can do for him. Dr. Calvert, the pediatrician that they are with right now, has upped his meds, doubled them from what they were before, trying to keep him calm. Hopefully, it doesn't put him to sleep, because he's on Concerta, 56 milligrams twice a day, plus Strattera, plus risperidone. So he does get a large dose of medicine to try to help him when he's in school. Mind you, when he comes home, the medicine is not working and I get the brunt. He's slow too; he's a year behind in his schooling. He's developmentally delayed, but just a little bit.

They both are very volatile, and for me it's very frustrating to try to deal with this and to try to help them to get through all these little nitty-gritties that they're doing all the time. It's hard for me to do it by myself. I do get a CCAC worker for one hour a night so I can cook their supper. She helps them a bit with their homework and then I finish it with them later. I get that hour break so I can cook, because I can't cook very well with them around. They are always running in, and I'm afraid of them—because they're not afraid of anything, they might pick up the frying pan or whatever I'm doing, boiling water, so I have to be very careful with them.

I'm told I have to stop now. Sorry.

Mrs. Christine Joseph-Davies: I'm Christine Joseph-Davies, and I'm raising my grandson. My stepdaughter is mentally challenged and she had a child, and the children's aid called us and told us that if we didn't take him—go through the kinship care program and take the child—that he would be put up for adoption. There's nobody else who would step forward, so we did, and we had to jump through all the hoops that the children's aid put up, fast-track into the kinship care program. We're the first family in Hamilton to go from kinship to foster care and become foster parents.

We left the children's aid because of our grandson being diagnosed with autism. One of the problems of having an autistic child is getting the diagnosis. There's a two-year waiting list to see a doctor who can say if he is or isn't autistic.

I know that in other cities the grandparents get financial support. In Hamilton, some of us do, some of us don't. I don't. People assumed that he was fetal alcohol; they also assumed that he was my child. I have a lot of prejudice against me, being native. I'm getting it from both sides. In the native community, we believe it takes a village to raise a child, but a child belongs with his parents, so my culture, my people, have kind of pushed me aside because I'm going against my traditions by raising my grandchild.

My "baby" is 24 years old, and I didn't think that I would ever be raising somebody else's child at this age. It's almost like being 16 and finding yourself pregnant

and stuck. My life is over in a sense, but my life is beginning again. My life revolves completely around my grandson. We haven't been out together in four years, because nobody can take care of him. He doesn't talk, and he won't go to anybody but us.

After we finished the kinship care program and he came to live with us, he was about three months old, and about three pounds also. He was addicted to crack and his intestines didn't grow. There are all kinds of physical ailments wrong with him. He stayed in the custody of the children's aid but lived with us until he was nine months old, and they pushed us and pushed us and pushed us to get custody of him, and then once we got custody they dropped us like a hot tomato. There was no financial help whatsoever.

We were 44 years old, both of us, when we got him. Brandon will be five in December. We didn't have a crib or a diaper or a toy, because our children had grown up and moved away. There was no help, nowhere.

So you're kind of on your own. There's no help, nowhere. The mother is in the HOMES program in Hamilton—it's for mentally challenged adults—and she doesn't have a care in the world. She has her freedom and her life is great.

One of the things that I feel I'm always yelling and screaming about, maybe: She goes to these mental health support group meetings and she meets men. I believe that they should be segregated. There should be males and females. One of the side effects from the antipsychotic drugs that she has to take is a higher libido, so you have all these females who are mentally challenged and these men are looking at them, and if you look at a mentally challenged woman for more than three minutes, obviously you love her, and she's going to sleep with you. That's what's going on, and that's how Brandon was born. I just think those meetings should be separate.

Help should be available. We've gone through our savings. Having an autistic child, they don't automatically get diagnosed. You're put on a waiting list. We're on a waiting list for—I think we have two more years before he can see an autism spectrum disorder team in Hamilton. So it's a long process, and it's hard. We need support: financial, mental and emotional.

Ms. Diane Chiarelli: Good morning. Our organization, ROCK, recognizes the huge impact that mental illness and drug and alcohol addiction have on our community. It's quite serious; it's like a huge ball of wax that you can't unravel. There are just so many directions and places that these addictions and mental illness cause valuable resources to be just used up immediately, leaving the community almost bankrupt.

We are very active in our community, not just with the fact that we raise our grandchildren, our extended family, or have struggles. We all have huge struggles; they're not insurmountable, but they certainly are difficult. We lobby the government. We truly feel that change starts with each of us within our community. We make certain that we have people made aware of resources that are available to them and get them there.

Part of the problem within our organization is that many of the grandparents are raising what you would call children who have been born as a result of mental illness or drug addiction. A lot of them do have significant disabilities. So you have a grandparent who is trying to deal with a parent who is mentally ill and challenging you at Family Court, or a mentally ill parent who is on a supervised access program, and then you have a child who is suffering as well.

We truly believe that there's a cycle as well with mental illness. A lot of the individuals are incarcerated and then either are released into a lodging home or become homeless, which causes a circle, because then they commit a crime if they are not on their drugs and are either rehospitized or back incarcerated. It's a very difficult cycle to break.

We feel that there are not enough supports in place, or maybe not the right supports. We feel that these individuals truly are suffering. They have a daily battle with depression and addiction, okay? Nobody wakes up one morning and says, "Jeez, today I choose to be mentally ill." This person does have an illness and they're suffering. It's the same with a drug-addicted person.

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I think we feel, the whole membership in our group, that we must make a concentrated commitment at all levels of government to support and create new programs and continue funding good programs to help these suffering individuals. We can't allow them to fall into the cracks, because when we do that, we have significant problems within our community that could have been prevented. We have to focus on the very real fact that their human status must be restored. These people are suffering. They need that support and help and need to realize that there is hope in life for them. We have to allow them to step out of their shadow of despair and hopelessness and step into the light of hope.

As members of our community, we must be accountable. If we're not mentally ill, if we're not drug-addicted, if we have the intelligence, we have to be accountable to bring programs and assist these members of our community. It is vital to the community. Some people say nothing changes; however, it does when all members of the community and all levels of the government come up with a vital and viable solution to these problems.

I believe that it exists. There are solutions. I believe that we can find the right solutions and programs for these individuals, that we must to protect the future generations that follow. You can have chaos like this: communities losing all their funding; homelessness; crack addicts like we have in Gore Park, and the mentally ill going there because they're out of the lodging home. It creates such a mix, it creates significant problems for the community as a whole. I believe that we will find a solution if everybody remains committed. Thank you very much.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Barb, Bev, Christine and Diane. Unfortunately, you've used up all your time, but you gave a wonderful presentation.

MADHURI AND KRIS RAMAKRISHNAN

The Chair (Mr. Kevin Daniel Flynn): If we could have the next delegation come forward, Kris and Madhuri Ramakrishnan.

Ms. Madhuri Ramakrishnan: He's just trying to hook up the computer.

The Chair (Mr. Kevin Daniel Flynn): Okay. Well, if you can make yourself at home there.

Ms. Madhuri Ramakrishnan: Okay, I will do that. Thank you. Good morning.

The Chair (Mr. Kevin Daniel Flynn): Do we know if the computer works?

Ms. Madhuri Ramakrishnan: Our computer works. We are just waiting for it to be connected.

The Chair (Mr. Kevin Daniel Flynn): Just while we have a second, for those members who are checked into the hotel, we need to all be checked out by 1 o'clock.

Ms. Madhuri Ramakrishnan: Maybe I can start.

The Chair (Mr. Kevin Daniel Flynn): That's fine. If this is only going to take a second, we can wait. If I was doing it, it would take about a half of an hour. That stuff—

Ms. Madhuri Ramakrishnan: That's why he's doing it.

My name is Madhuri Ramakrishnan and that's my husband, Kris, working on the computer there. Kris is a retired engineer and I'm a retired banker. Our son, who is very bright, when he was going to high school initially was a very popular kid and had a lot of friends. As he grew up, near the senior years, we noticed that he was losing his friends and was becoming more of a recluse. We kind of attributed it to the teenage years, growing up, hormonal changes, and figured he would grow out of it. So that was our assumption at that point. He went to the University of Waterloo in 2000 on a math scholarship and he went through university on and off, changing subjects.

In the summer of 2004, he came home for the summer. He could not hold on to a job, and we noticed that there was a great difference in his behaviour. We were getting concerned. We had him checked out. Physically he was fine. He was sleeping erratically. He would pace all night and sleep during the day. His behaviour was not consistent with who we thought he was. Our son is a very gentle, sensitive person, and he was violent towards my husband, pushed him a couple of times and swore at me. It was totally uncharacteristic of him, and we were getting quite worried. I spoke at the time to St. Joseph's, spoke to a resident psychiatrist because I didn't know what I was dealing with. We spoke to our GP and even spoke to COAST in Hamilton, which was the only one available at that time, but since we live in Burlington we could not use any of those services. Based on all the recommendations, we took him to Joe Brant Hospital in August 2004.

When we took him to the hospital, he was admitted first on form 1, which allows them to keep him for 48 hours, and then on form 2, allowing them to keep him for

10 days. We found that the nurses in the psychiatric ward weren't very knowledgeable. They said, "If these people just took the medicine, they would be fine." They didn't seem to have any compassion or any empathy towards the consumers, as the patients are called. We found that there was no information on mental illness. We had to look around to find even a pamphlet on SSO, which is the Schizophrenia Society of Ontario. When our son was put on form 2—they get legal rights, as the earlier person talked about, so they get a lawyer and they go through a review panel. He was allowed to come home. However, I was given the authority to administer the medicine, which really doesn't work. The psychiatrists there, again, were pushing pills, were not telling us what it was all about and not explaining what it was to our son, which does not help them because then they don't adhere to the treatment. They relied on the case managers to tell them what is going on, and the case managers are not always available. So when we came home and we needed the case manager, if they were not available they told us not to call police if it could be helped because only two police officers in Halton were trained to deal with mentally ill patients; otherwise, they might be handcuffed or tasered, and that was not a desirable situation.

With his medicine, there were many side effects. There was weight gain, which is a common side effect. When we would go to the psychiatrist, the appointment was given every six weeks and he would only spend about 10 minutes with our son and really did not ask him about his symptoms. His symptoms were, apart from weight gain, that he had erratic leg movements, he was pacing, his eyes were blinking and the anxiety was tremendous; he was very anxious at all times. This meant that we as caregivers were pretty well house-bound. We don't have any other family here, so there was no other help, and because of the stigma attached to mental illness, it's not always easy to start admitting this to your friends; you have to weigh the pros and cons. We had to be home all the time, constantly comforting our son. That meant there was no respite.

Then we attended the strengthening families together program with the Schizophrenia Society and found out that another set of parents had a similar experience with Joe Brant in Burlington. They were not happy with the medical team there. They told us that they took their son to CAMH, the Centre for Addiction and Mental Health, and their FACT Peel clinic in Mississauga, to the psychiatrists there. With great difficulty, Kris got our son into the early psychosis program there. Again, because we were in Burlington, it was difficult because they did not deal with Burlington; when we did get in, we found that the psychiatrist's whole approach was different. He and his case manager spent an hour and a half with our son and spent an hour with us. Even now, with all our appointments, they make sure that we are also heard and they talk about the medicine, they talk about why they're doing what they're doing. They also provide other help to the consumers. They have games day there, they take them out to different activities and they have counselling

for parents. So the help that is provided by them is quite exceptional and was a lifesaver for us.

Now I'm going to let my husband do the balance of the presentation.

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Mr. Kris Ramakrishnan: The one great advantage our son has is his desire to study, which helped him immensely to realize that he wasn't doing well, and he went to the University of Waterloo. At Waterloo, he didn't take his medicine because he didn't believe it would help him.

CAMH has a remarkable case manager who went to Waterloo on her own time, along with a professor who took great interest in our son and the disability services in the hospital. They convinced him to go to the Kitchener-Waterloo hospital. We didn't realize how bad he was at that time because he was off the medicine. With schizophrenia particularly, or any mental illness, if you stop the medicine, it attacks you with a vengeance.

The hospital doctor, without checking anything, sent him back to the residence, saying, "You can walk there," which is about three kilometres. We didn't realize at that time that our son had a habit of thinking he could stop cars by crossing the street, holding his hand out and touching the car. He was a danger to himself, but the doctor discharged him. We went there because we talked to him and we found that he was incoherent. We went rushing there, and we couldn't find him. Then we called the police; they couldn't find him either.

We called the hospital and they said, "We won't do anything till 8 o'clock. That's when he's supposed to come back." But we said, "He's not in a position to go anywhere. He thinks he can stop traffic by going and standing in front of cars." Luckily, our daughter was a crown attorney at that time in Toronto, working for the ministry. She has a master's in neuroscience from McMaster University, so she's familiar with mental illness. She spoke to the police because we were concerned about what the police would do, because very few are trained in how to handle mentally ill people. They could taser or shoot them. She spoke to them, and the police were just going to put his picture on the local television. Then we phoned the hospital. He was back, which they were supposed to tell us, but they never did. We went to the hospital and saw him. We were shocked at the condition he was in, and the doctor had sent him out of the hospital. Then we spoke to the doctor. She realized her mistake and then kind of apologized. She put him on form 1, which is to keep him there for 24 hours. He refused to take the medicine. It's different than at Joe Brant, in the sense that they were all given rooms. I've worked for a lot of industries, travelled around the world. That's the worst thing you can do: put people in rooms with telephones. They never came out of their rooms. They monitored all their calls using voice mail. You couldn't talk to them and neither could they; they only came out when it was necessary. The whole thing was like a jail set-up with big fences and other things. Joe Brant is at least on the lakeshore here; you could walk around on the nice grounds. This reminded you of a jail.

Then we moved heaven and earth to move him to CAMH in Toronto, which is on College Street, because our doctor was from CAMH. We found there, again, that in the medical system all are not equal. Some of the nurses there were very good; some just sat in their office and never came out. Our son thought they were the best nurses because they never bothered him with medicine.

Our son fought tooth and nail. We are very proud of the way he behaved with all the form 1, form 2, form 3, form 4—all this to keep him to get him to take the medicine, because he refused again. Then the medicine he was on wouldn't work. That meant he went to a third medicine. At that time—even now, almost—in Ontario there are only four approved medicines for mentally ill people. The first one, in Joe Brant, had side effects. Number 2 was working well, then he stopped taking it; it didn't work in CAMH. Then he was on number 3, which caused high anxiety. He was curled up in the fetal position most of the time in the hospital; we didn't know what to do.

But I had read at that time—there is a book by Dr. Tory about mental illness. There are other medicines you could use to reduce anxiety and remove side effects. I asked the psychiatrist there, "Why don't you use them?" He said, "No. These people have trouble taking one medicine. How can they take three?" He forgot that there are caregivers who are begging for this.

If the Risperdal didn't work, there was only one medicine left, which very few people can use, and it has phenomenal side effects. So what are you going to do? There are only four medicines. At CAMH, being a research hospital, they said, "Don't worry. We can bring medicines from India on a research basis." There are 20 approved in India, 14 in the United States and about 12 in the UK. Here there are only four. Luckily, Risperdal worked and they discharged him home.

Then we went back to our FACT Peel illness outpatient ward, and there was what you call a CTO, a community treatment order. A community treatment order, we found out—we asked CAMH to give one, which makes the patient take the medicine. However, it's toothless in Ontario. You have no power. Ontario rights are very high. It's useless. He said, "There is no point in you having a community treatment order because you can't force him."

Consequently, our son had tremendous anxiety attacks caused partly by medicine and partly by illness. He would go around stomping his feet all along—we took long walks with him in Burlington, constantly comforting him. He would lie on our laps for hours, and we couldn't go anywhere. It was a bit worse than when it started in 2004. We were totally homebound. We both decided to retire and work from home only. I could rarely work at home. Sometimes he wanted me home; sometimes he didn't want me home. I went to every Tim Hortons you can think of with books when he kicked me out of the house, even the senior citizens' centre to sit and read because they have the nicest chairs in Burlington. He wanted constant comfort. He suffered from all these effects.

Then I became a volunteer for COAST in Burlington, which started with a guy in Hamilton. I phoned; it was a table like this in this meeting, an advisory council, and there were 23 agencies representing mental illness. There was no single forum to know what all these 23 agencies did—each one on its own—so I started on my own, collecting data on all these agencies and what they do. Nowhere was it published that there are 23 agencies in Halton which handle mentally ill people.

Our son then decided to take the medicine, after a lot of convincing, and he went back to the University of Waterloo. This time he was doing well, and every day we would drive him to the University of Waterloo. He was anxious on the way, so we had to constantly comfort him and give him additional medicine when required, when he decided to take it. When he was in school, we walked around all over the place. We made daily trips to Waterloo, regularly.

Then he decided to go to teachers' college, because he was associated with the teachers' college in North Bay. In North Bay, the teachers' college has a theoretical portion as well as a practical placement portion. The placement portion—it's like a union. I'm an engineer, my wife is a doctor, and all my colleagues are doctors, every one of them. But every disability department in the placement place there considers a mentally ill person the same as anybody else. They should do exactly the same thing as others regarding placement.

In North Bay, at Nipissing, there are no—the disability department is super, but the placement department sucks, and they didn't help him anyway. Later on, we found out that U of T, for those who are mentally ill, has a mentor as well as a mock setup to make them work. It seems that Brock, Queen's—everything is different. The McMaster disability department, the Waterloo department, they all have their own independent entities, and they all work totally differently.

Our son had constant panic attacks due to this placement dealing with kids who are not totally disciplined, and we had to start at 6 o'clock, phoning him and giving him encouragement to go to his schooling. We made many, many trips to North Bay.

As caregivers, we found there is really no help available, because we can't leave the house. We have to look after him. He's much, much better now. We can go now. Those days—for four years, we couldn't go anywhere or do anything, whereas in BC the law allows two hours of time for a psychiatric nurse to look after a caregiver. Saskatchewan also—the CTO has got power; Ontario's doesn't. And in Halton, those who have Alzheimer's disease can get two hours of respite care, paid for by Halton region, whereas there's nothing for mentally ill patients.

We have certain recommendations. Start with schools and universities. First, with schools, tell all the symptoms so that the teachers are aware of what symptoms to recognize, because the earlier you treat them, the better the chances are.

Bring proper disability standards to all universities. They vary widely. Some are good, some really suck. And

there is a lot of stigma, so we couldn't tell the university or anywhere what was wrong with our son. We generally would say that it was non-physical, so of course they guessed. So that stigma—something must be done with PR or television.

There should be one centre established—I heard at a meeting that Peel is kind of trying to do this—which talks about training the nurses so they're aware of what medicine they use and how to use it. They don't know. I had to tell them sometimes, "You can't do that," what they were trying to propose, to cut the medicine and give it to two. It disappears in your own hand. The nursing supervisor said, "This is all we get. What can we do with them?"

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Then the psychiatrists, they are not the same. Some are good, some are just pill pushers. We need cognitive therapy to overcome anxiety, apart from medicine. So that is not freely available. There should be a one-stop centre where you can go and get all this help and this should be widely publicized. We need more medicines, at least as much as the United States, and use of multiple medicines must be promoted, which is what is helping our son. He's got a master's now in Waterloo, and then he wants to do a PhD. Luckily the professor is super-duper. Multiple medicines help, which a lot of psychiatrists are not using because they lack knowledge. They sit in their offices and push the pills. Provide a CTO with teeth for parents like us caregivers so that if the people don't take medicine, they should be helped. Additional help is required.

Ontario is the most liberal of all the provinces and the patients have all the rights. We fought tooth and nail in all these hospitals, how to get through the forms. CAMH has got it to a perfect art and a science. Without that help, we couldn't have done that. The CAMH psychiatric approach should be put into all the community hospitals. They are all low standard compared to CAMH Peel.

The rights have swung too much toward the patients. Once upon a time it was bad; they were in prison, they were treated rotten. Now it's gone the other way, and the caregivers are left holding the bag. And if you take the cost—where is all this cost going to come? An average mental health patient stays for 37 days in a hospital against three days—this is what I read in the Star—for a normally ill patient. So you can avoid a lot of these things and help us to help our children and others by providing more medicine, better schooling, better—this thing. At least people with mental illness like we are dealing with, it would help.

We're still not having vacations, but it's much better because we are one of the fortunate ones. We did a lot of research and fought with psychiatrists and everybody to help our son. And his great desire to study helped us.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for your presentation. There really isn't time for any questions. There's a little bit of time left, but I think you got your point across very clearly.

Mr. Kris Ramakrishnan: Thank you.

Ms. Madhuri Ramakrishnan: We urge you to look at our recommendations and consider them very carefully.

The Chair (Mr. Kevin Daniel Flynn): I can promise you the committee will do that.

Ms. Madhuri Ramakrishnan: It will help all people with mental illness and their families. Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming.

BURLINGTON COUNSELLING AND FAMILY SERVICES

The Chair (Mr. Kevin Daniel Flynn): If we can call forward our fourth presenter of the day, somebody I know well, Susan Jewett, executive director of Burlington Counselling and Family Services. Good to see you, Susan.

Ms. Susan Jewett: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Make yourself comfortable there. There is some water. Everybody in our hearings across Ontario is getting 20 minutes. You can use that any way you like. If there is a chance to leave any time at the end for questions from the committee members, that would be great, but it's not necessary.

Ms. Susan Jewett: Okay. Thank you very much for inviting me here today. I'm Susan Jewett. I'm the executive director of Burlington Counselling and Family Services. I'd like to acknowledge your Chair, Kevin Flynn, who represents Oakville. It's part of the community that we serve. I see Kevin frequently out at community meetings that deal with issues of poverty, mental health and addictions, and we really are delighted that he's chairing this committee. I think you're in good hands.

I've taken the time to review most of the presentations you've heard prior to today and I want to try only to add a few new points and build on others. There are almost 50 family service agencies across Ontario but I'm going to speak mostly about our own in Burlington.

We are what I would call a secondary level type of service. If you think of GPs as being primary care and some of the services that you just heard about as being more specialized and tertiary, we're more an entry point for the broader community who may experience any kind of mental health or addiction issue. People will come to us who have experienced trauma, depression, crippling anxiety, family separation, grief and loss issues, and abuse at some point in their lives. Some will suffer in silence while others will reach out for help; some will attempt suicide or high-risk behaviours; some will numb their pain with alcohol or drugs; some will be killed by their partner. Children are greatly affected by these types of family crises. They may be the invisible victims or they may develop problems of their own, and during a recessionary economy it only gets worse. Our services help get people back on track. We're part of the system that builds stronger families in the community, and I

think family service agencies are part of the solution that this committee needs to consider.

We don't tend to use the words "mental health" or "mental illness"; we talk about counselling services. But in reality, most of the people we serve come with mild to moderate mental health problems. Our budget is just over \$1.1 million—I'm going to tell you where it comes from, but I want you to listen for the silos as I describe our funding—of which 65% comes from the provincial government, 7% from the region of Halton, 7% from United Way, and the remainder is raised through client fees, employee assistance programs and other small grants. You will notice that we have no funding from the Ministry of Health and no funding through the LHINs, although most of the people we serve have mental health problems.

Over the past two years we participated in a study, and I've outlined a bit of it in my report, but what I want to highlight is that that study looked at 2,100 people served through family service agencies in Ontario and it demonstrated the impact of our service: 62% of the individuals served with moderate mental health problems demonstrated a significant improvement in their symptom reduction and their overall life functioning.

I'm sort of skipping, if you're following the report, because I'm afraid I'll run out of time. I want to emphasize a point about children and the need to improve mental health services for kids. You've heard that from a number of previous presentations. I support that 100%. But we must never forget that most kids live in families, and we can't have emotionally healthy kids without working with the families too. Depressed moms have trouble parenting; alcoholics make poor parents; families in which there is violence tend to raise kids who think that violence is acceptable. It's hard for kids to keep it together when their families are falling apart. So count on us, family service agencies, to provide these very needed services for the family.

One of our areas of expertise in Burlington is family violence. Again, let me tell you where our funding comes from and listen for the silos. We receive funding for counselling for women who are victims of abuse and their children—it's from MCSS. We have a partner abuse program, which is for people who perpetrate the violence; it's primarily men, but not exclusively men—that's from the Ministry of the Attorney General. We have a caring dads program, which is for fathers who have a history of abusive behaviours—it's from a grant through Halton region. Our supervised access program provides a safe place for children to visit with their non-custodial parent; many of these families are referred to us through the court and they have a troubling and lengthy history of family violence, severe mental health or addictions—again, funding is through the Ministry of the Attorney General.

Let me be clear: Family violence is not caused by mental health or addictions. However, there are significant links with these three issues. I hope you will have an opportunity to refer to the Ontario Domestic Violence

Death Review Committee reports and their many excellent recommendations, which address the connections between family violence, mental illness and addictions.

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Let me tell you about Sam; that's the name I'll give him. Please listen for the impact of funding silos. Listen for the stigma and the sense of shame, and lastly, listen for the entry point into the mental health system, if we want to call it that. Sam was referred to our partner abuse program; that means he was already accused and found guilty of abusing his wife. So he entered the system through the police and the courts. He arrived at our program, he was seen by a counsellor, and prior to that he completed what we call the OQ-45. It's an outcome measure tool where someone assesses themselves on 45 variables. When he did that, he informed us that he considered taking his life frequently.

When we interviewed him, he denied that. We hadn't seen what he had written, and we always ask about suicide tendencies. He said he didn't have any. And so we moved on to talk about the abuse that brought him to our door and what the program had to offer. When he left, he was given a date to start the program a few weeks later. He didn't come and he didn't cancel. We followed up with a phone call, couldn't reach him and had to leave a message. We didn't hear from him again. A few weeks later, we learned that he had died by suicide.

So here's an example of silo funding. People don't come in the silos that we're funded in. They come with a multitude of problems. He could tell us in writing that he was suicidal, but we think the shame and the stigma—he couldn't tell us when we were asking him. And because we weren't really funded to deal with his depression, we proceeded with what we thought we had to do. We won't make that mistake again, but it's partly pushed on us by the way we're funded. We need funding that is flexible enough to respond to people's needs, not for one issue with the assumption that one size fits all. We work in silos because we're funded in silos. All of our provincial funding is to deliver a certain program in a certain way, no exceptions.

Let me say one other thing about the partner abuse program. It was designed to be an early intervention program, so people with a fairly mild, if you can use that expression, incident of abuse where the police have been involved. It's unfortunately the only program, so we cannot accept voluntary people, we can only accept people who are sent to us by the courts, and because it's the only program, even though it's early intervention, we will be sent everyone, whether he's an 18-year old who assaulted his date, whether he's an 80-year old who's been abusing his wife for years or, as in one case recently, whether he is a man who "accidentally" killed his wife. I don't call that early intervention, but that's the only program funded, and so they come to us.

Most of our funding from the province requires us to provide a certain number of services for people a year. That's understandable. It doesn't fund us to coordinate service, and we deal with people with complex problems.

We need to be able to work with other service providers and coordinate our services. Let me give you an example: Joe Brant—and you just heard of them—had, a couple of years ago, a woman who was admitted. She had been shot by her husband. She lived. Her child died. They treated her physical wounds and they called us to say, "This has been a horrible tragedy for her family. She needs help, Susan. Can you take her? And oh, by the way, she only speaks Arabic." We were delighted that this was a good example of coordinating the service. Yes, we could do it; yes, we could do it in Arabic; and yes, we could do it today if she was able to come, and they sent her.

But we don't have funding that encourages us to coordinate, and people fall between the cracks. Most of our families are involved with justice systems, children's aid, children's mental health, the hospital, or some combination of all of those, and we need funding that allows us to work together with those other communities. Some communities have developed co-located services, buildings where a number of agencies work together out of one site. I'd encourage you to look at some of those innovative, community-based projects.

In another presentation, it was mentioned that we have a two-tier system for people with mental health issues. Certainly, in our community this is true. People living in poverty who have mild to moderate mental health problems have far less access to service than people who can afford to pay. I have this bumper sticker on my wall: "My Ontario includes the poor." I hope your strategy will include them too.

People who live in high-growth areas, such as Halton and the GTA 905, have far less access to service because funding is usually historical and does not address population growth or decline. The Auditor General spoke to this; I'm not going to go on about it. But every year in high-growth areas we fall further and further below the provincial average. There has to be some way of addressing these inequities so that people all across our province have equal access. The funding does not need to be based on population alone. It should be a combination of population and social indicators. But history doesn't work; we know that.

You've also heard from other presenters that 80% of people with mental health and addiction problems go to their GP for help. There is an innovative model of service that was recently developed in Waterloo region and is funded by the Ministry of Health. It's called Health-Connect Counselling Partners. I've included a brochure in my package for your review. Family doctors are able to refer any of their patients with mental health issues to this Health-Connect program. It's a group of six agencies that all provide different types of counselling, and there's one centralized intake. It helps the doctors deal with the issue that they don't have time to treat people for and allows them to focus on the areas that they do. It's connected to the family doctors, so it's a wonderful way for family doctors, who are seeing 80% of these people, to refer them on to a system that is community-based. I again encourage you to take a look at this type of model.

Remember Sam? He's the young man who was also suffering from depression and took his own life but who came to us for partner abuse. I often wonder what would have happened to him if he had entered the system earlier through his GP rather than through the justice system. If we had had this type of model in Halton, perhaps he'd still be with us today.

Dr. Gina Browne, who's a Burlington resident but works at McMaster, has done numerous studies which demonstrate that providing counselling along with a range of other services saves millions of dollars because it reduces the use of more intrusive services, more specialized services, and it reduces the length of time that people are financially dependent on the province. I've put some material in my package about her work as well.

In closing, let me make one more pitch for strengthening family service agencies across Ontario as part of your strategy. We are community-based. Most of us are open long hours and are available when families need us. Most of us offer services in a number of languages. We work with other service providers. We have a long history of serving families across Ontario.

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My recommendations, in no particular order:

We must reduce stigma.

The gross inequity in funding for mental health services versus physical health services must be addressed.

The inequity created by funding which is historical must be changed.

We must develop strong, community-based secondary level integrated mental health and addiction services.

We must address the funding in silos, which create barriers.

Finally, we do need a champion to move this work forward.

Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Susan—a very comprehensive presentation. You've left time for one, maybe two questions. Helena has the first question.

Ms. Helena Jaczek: Thank you for all your points, excellent recommendations. We've certainly heard some of the same themes. I'm impressed with this Health-Connect piece that you've drawn our attention to.

You make a point of saying that your counsellors are master's-prepared. Have you used peer support workers, peer navigators?

Ms. Susan Jewett: In our agency, no, but some other family service agencies may have.

Ms. Helena Jaczek: Is that because you don't need to or it doesn't fit or you—do you have a sense of the value of that program?

Ms. Susan Jewett: Yes. Partly what we provide is what we're funded to provide and all of our funding is program-specific. So it doesn't leave us room to expand or try new things. We must deliver—

Ms. Helena Jaczek: You don't have the flexibility—

Ms. Susan Jewett: We don't. Some are larger and they do. We don't.

The Chair (Mr. Kevin Daniel Flynn): There may be time for one more brief question. Sylvia?

Ms. Sylvia Jones: It will be brief. You mentioned a lot about the silos. Some of the presentations previously talked about the need for one ministry taking the lead. Do you have a comment on that and, if you do, a preference?

Ms. Susan Jewett: A preference of ministry? I can't speak to a preference of ministry but I do think that is an excellent solution, having one ministry or one lead in the ministry. One of the huge silos is that the ministry people at a program level don't connect with each other. So they have a barrier within the provincial government itself, which quite frankly ripples all the way down to the community. If there is any way to address that, I highly support it.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Susan, and thank you very much for coming today.

Ms. Susan Jewett: Thank you.

JUDY TYSON

The Chair (Mr. Kevin Daniel Flynn): Our next presenter this morning is Judy Tyson. Judy, if you'd like to come forward and make yourself comfortable. I don't know if there are any clean glasses left. There may be one down at that end of the table and I think there's some water left there if you need some. The trick is going to be making sure you pick up your own now.

Ms. Judy Tyson: It's true. We'll better the odds here.

The Chair (Mr. Kevin Daniel Flynn): Okay. Like everybody else, Judy, you've got 20 minutes to make your presentation. If you can leave some time at the end, that usually works better, but it's not necessary. The microphones work better when you're about a foot away from them.

Ms. Judy Tyson: Good to know.

The Chair (Mr. Kevin Daniel Flynn): It's all yours.

Ms. Judy Tyson: Thank you. Good morning, ladies and gentlemen. I come to you as a family caregiver whose family experiences have led me into some interesting adventures in non-profit groups and with the Mississauga Halton LHIN.

There was an advisory team that last year was called the detailed planning and action committee on mental health and addictions and this year morphed into SIGMHA, the system integration group for mental health and addictions. We put out a rather lengthy report, which is available on the Mississauga Halton LHIN website, on what we thought were the priorities in mental health and addictions integration.

I'd like to discuss a vision of good health care for mental health and addictions as I have experienced it and what I've grown to see as some of the obstacles. It's devastating to families—I'm sure you've heard that repeatedly—but what I don't see is a great deal of benchmarking for the care. I believe in bold policy and legislation, but I don't envy your job. I don't know where you start—it's a big job—but here are some priorities that families might put in higher priority.

No wrong-door access: Some of the organizations talk about one door. I don't know that that's possible, but where are the entry points to the system? It could be EMS, it could be a GP's office, a prison, long-term care, a school or a mobile unit police car. If you're thinking of education and training, that may be one place you should start to look. If you look at technology as a solution, the technology should connect a client to a service immediately upon intake. Even if it's a transitional service, I can't overestimate the necessity of having trust in the system right from the first encounter, both for the client and for the family. Navigation, as you've heard repeatedly, is a big issue.

Retelling a story could be eliminated by centralized systems, with a patient history that's accessible by all agencies, integrating primary care and mental health and addictions. What I don't understand is why we have to wait for six more years for the electronic health records to come on board. It's clearly going to be a big leap forward.

An inventory of services that's available on the web would assist providers and encourage a self-help strategy for people in crisis. We are capable of doing our own research to a certain degree, but we don't always know where to look.

Assessment and discharge: It's a critical first step that could save years of personal loss and avoid the revolving door. My business is marketing communications, and what we promise our clients is that it can be good, it can be fast or it can be cheap—two out of three—so we understand trade-offs, and I think clients and families do too. Trust is important, but nothing can get started without the proper assessment. The wrong assessment can set clients back years and lead to devastating effects. Discharge can't be into a vacuum. I think the importance of care coordinators or case managers can't be overestimated.

There also has to be a care path or a continuum of care, whatever the language is for that. The guiding principle here is to never abandon or isolate a client. Start with a plan that's flexible to fit individual needs, and then the go-to guy should communicate it to clients, agencies and families. There are agencies out there that don't know about each other, that run into each other anecdotally in a seminar or over lunch and learn or whatever, and that shouldn't be happening. I think there should be audits throughout the treatment to see if the treatment is working. If that care path is accessible electronically, it will encourage self-management, family participation and workflow planning with the agencies.

Collaboration and non-exclusionary criteria can prevent the "pong" effect—clients just bouncing back and forth between agencies.

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Counselling: One of our surveys on the DPA team said, "When you need a drink every day, you need counselling every day." Counselling is fundamental, but it's not a magic bullet. The weaknesses, of course, are long wait times—sometimes six months to get started with

counselling. There are work complications, transportation issues, and some people are trying to manage a career and family life while managing their disease. What are the alternatives? Well, as we've discussed, peer support groups, online forums, phone conversations—that's not new technology—messaging. Some of our kids are managing three or four conversations at one time when they're messaging each other. That can possibly fill some gaps. I read a headline in the *Globe and Mail* about shrinks online. Why not? That delivers service when it's needed, not on a monthly or weekly basis, on a schedule.

Cognitive behaviour therapy was also cited as an important step in self-management, which is a goal for our group.

Family support, because families are the main caregivers. I put in more hours than any other caregiver in my father's and brother's care. But the ripple effect of the disease is devastating: the shock, the guilt, the confusion, fear and shame. It wipes out our assets, alienates kids, ruins marriages and careers.

What do caregivers need to know? In some cases it's the same that clients need to know. They need to know about the progression of their disease and what the behaviours are, and what the needs are short- and long-term.

A web link to a reliable source of information would be a good first step. I don't need to take time off work and go to a seminar where there may be people with a number of different mental health and addictions problems that aren't specific to my needs. An e-mail from a case manager keeping me in the loop, as a family caregiver, is a really important step. Communications—I can't overestimate—is a really powerful tool, and most of us have access to electronic communications.

Medication is also an important issue to me. Bad meds can cause more problems than they cure. An example is Paxil, which is an SSRI. It has a known high suicide risk, and the people I know who've taken it, for example, have had more complications from it than if they didn't. Evaluating the performance of pharmaceuticals should never stop. A pharmaceutical that comes onto the market should be on permanent trial and should be tracked, right from its first entry into the market. There may be issues of interactions, consistency and double-scripting, and hopefully the EHR will help with some of those complications.

Clients are holistic beings, and I think you have to look at their care in that way. Treatment has to be client-centric, not system-centric, which is not to say the system shouldn't be very strong in enabling that care. Clients need meaningful work, transportation, housing, financial assistance; these are all important to recovery.

Education and training: Working on the education and training group, I've put together an exhaustive list of target audiences, and I notice that the mental health committee, Michael Kirby's committee, has prioritized two groups. One of them was service providers, which includes GPs, because I understand that their training and education is very deficient. Someone told me it's only

one month in six, seven or eight years of training, and they are usually one of the front lines. The other is the educational system. In the educational system you will reach teachers, who may be the first line of recognizing symptoms; curriculum administrators, who can put this information on the curriculum and start teaching children from an early age how to recognize or understand illnesses; future adult citizens, who are coming up through the educational system; and parents and school administrators. That hits a lot of people at one time. Prevention should be part of the message to address the stigma.

I think the key themes in this part of my address are innovation and initiative, management and logistics, integrating primary and mental health care, client-centric and holistic care, benchmarks, communication and collaboration. All of these terms are business terms; we use these terms in business. But from what I see of the service providers that I've had dealings with, they're resisting the business model. So the tail wags the dog, and then the system just spirals down with disconnect. Management of a complex organization is a science, and very few of us are skilled to do this; very few of us are successful at doing it. In mental health and addictions, there is an abundance of leadership. I am very impressed with the academic qualifications of the people I work with, many at the master's level, terrific at doing due diligence and analysis—and they do that to death. But there is no enterprise-wide operational management.

I propose seeking diverse skill sets. What about the logistics experts who bring bananas to our table from across the world exactly when they're ripe? I know you're going to think that's a ludicrous analogy, but there are some skill sets there in delivering service.

I'm very sad about the culture. Medical professionals are heroes and they're saving lives, but there's a toxic culture: entitlement, arrogance, competitiveness, skepticism of systemic change. The other edge of that sword is that they feel powerless, frustrated by bureaucratic blunders, indifference or lack of feedback. The only motivators are crisis and budget cuts. So they're not motivated to find efficiencies or they find the low-hanging fruit, like wait times, and the concept of creative destruction is a concept that presents a conflict of interest. They've got their head down the whole time.

I have asked questions: "Why are you doing things this way? Who's in charge? Why isn't there an execution plan?" and they say, "It's a slippery slope. Human factors are complex." Well, so is the internal combustion engine. "There's no money"—but I find that hard to believe, given that, what, 30% of GDP is for health care? "We need more due diligence. There's no feedback," and so on. But even a modest plan like co-location, which they're trying to do right now, was panned because they felt that the other agencies had no synergy or it was imposed upon them. The ministry hired consultants, but they feel that they weren't consulted on the changes. There is a disconnect with the LHIN. The disconnect with the LHIN is alarming, even anecdotally. When I see my surgeon friends, they say, "What is the LHIN? What

is their mandate? What are they doing?" And that's coming from doctors, advisory teams and the public.

As far as finding efficiencies, I saw some simple ones in education. In the private sector, learning happens at our own expense, on our own time, nights and weekends, and we pay for it ourselves for the most part. But there are some easy things that can be done, like online courses. They test your comprehension as you go ahead, and they can be accessed at the convenience of the person studying, and that could be service providers or families.

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Record your seminars and put them on the Web so that people can see them, so you don't have to keep paying that consultant over and over again to do the same seminar. Transcribe your workshops and make them available on the Web. Lunch and learn: Bring all your PSAs or your health care workers together in your boardroom instead of sending them halfway across town and paying to substitute for them. Bring them all together at one time. Put in a DVD and train them all together; video conferencing. Online calendar was a solution that we felt would help all the service providers who are trying valiantly to do education and training but have no way to connect to people either in the community or in other agencies. But that was not accepted by the LHIN. These are technology-focused solutions. The other is trying to prioritize the target audiences, which was another problem for the LHIN.

The hockey analogy applies here. You've got to skate to where the puck is going, not where it is now. The workforce of the future is crowd-sourcing. You don't have to pay for everything. There are people like me who are willing to give our time, and truly collaborative work is constructive work. It's disappointing to find that work that you do is not accumulating toward a strategic plan. A plan has to have a dotted line to an executional plan. There have to be accountabilities and there have to be some shared goals.

That's all I have to say.

The Chair (Mr. Kevin Daniel Flynn): That was excellent time management. You hit the nail right on the head. Unfortunately, there is no time for questions, but I think we all got your point.

Ms. Judy Tyson: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today, Judy.

JEAN WIEBE

The Chair (Mr. Kevin Daniel Flynn): Our next presenter this morning is Jean Wiebe. If you'd come forward, Jean, and make yourself comfortable, we'll get you a clean glass of water. As we're travelling across Ontario, every delegation is getting the same amount of time—20 minutes. So you have 20 minutes and you can use that any way you see fit. If there is an opportunity to save some at the end for questions, that's usually pretty good. The microphones work better if you're about a foot away from them.

Ms. Jean Wiebe: Okay. How's that?

The Chair (Mr. Kevin Daniel Flynn): That's perfect.

Ms. Jean Wiebe: Okay. My name is Jean Wiebe, as has been announced. Those magazines that were handed out I got from Bill MacPhee, who is the publisher of the *Schizophrenia Digest*, and it's located and published out of Fort Erie. I got these from him free for our walk for schizophrenia, which was held in May. I had them left over so I thought you might get some education about mental illness. There is one there about depression, and there are two about schizophrenia.

I'm not a speaker, I'm a mother and a retired registered nurse, so I'm just going to read my presentation. I retired from being a registered nurse when I was 55, 10 years ago. I worked full time at the St. Catharines General Hospital for 31 years. I worked in intensive care and I worked in the recovery room, but I never worked in psychiatry.

My son Jim got sick right after he graduated from high school. He was 19 in 1994. That makes him 35 now. He became withdrawn, stayed at home, lived in the basement. He became afraid, paranoid. He had a cut-off hockey stick that he put in the window in his bedroom so you couldn't open it and he had a baseball bat at his bedside. That was to protect him. He had delusions. He wrote in a notebook about our family being superior, and I was excluded because I had divorced his father.

He also thought God was going to kill him, and in the beginning I had to lie on his double bed beside him, both of us fully clothed, so he could sleep, because God was going to kill him. If I was there to protect him, then it would be okay.

He did not hear voices—he has never heard voices—but he did have what they call auditory hallucinations, and he explained them to me as being poppings in his head. I got him to the psychiatrist and he was put on the old medication, Haldol, which made him doozy, but the doctor did not put him on the drug to counteract the side effects. The side effect was that you lose control over your ability to swallow and you lose control of your tongue, and it protrudes. Unfortunately, that happened to him. We got him on the drug that counteracts that and then he was all right.

Then I asked for a second opinion. We went to that psychiatrist, and he was put on one of the new medications, called Risperdal. Within four to six weeks, he improved slowly. But that took about six months. He got sick in July, and this was in January that we got to the new psychiatrist. But people are not diagnosed with a major mental illness until they are sick for at least six months.

He was diagnosed with schizophrenia. I don't know how many of you people know, but just to let you know, the definition of schizophrenia is "a mental disorder characterized by impairments in the perception or expression of reality and by significant social or occupational dysfunction." That's the definition of it.

During this time, my son became honest with me. He told me what he had done as a teenager. He started drink-

ing when he was 14. He went on to use marijuana. He used LSD and he used magic mushrooms. He went to a rave in Toronto—I don't know if these raves are still going on; I haven't heard much of them lately—and he was given some sort of a sucker with some drug on it. He took it, and he didn't even know what that drug was. He just wanted to get high, I guess.

He didn't get any education at school about how bad street drugs and alcohol were, especially for young people, and I, as a parent, did not get any education about street drugs and how bad they are for young people, or alcohol either. We had no education in my nurse's training about addiction or alcoholism. And we had no education, during my 31 years of attending in-service education, about drugs and that. There was no in-service on drugs or alcohol, ever.

Doctors and nurses need more education about street drugs and alcohol abuse in young people especially. We need education for children starting in grades 5, 6 or 7, because the worst time to use marijuana especially is in grades 8, 9 and 10. This is when the brain is really developing, and marijuana has a negative chemical impact on that brain. This is from Dr. Archie, who is at the Hamilton Psychiatric Hospital now, or whichever hospital she's in—I don't know. She came and spoke to us in St. Catharines.

When my son Jim was 17, I thought that he was starting to drink. His father had a drinking problem. I started attending Al-Anon family groups. It was started along with Alcoholics Anonymous. These groups have been going on for over 50 years. Al-Anon family groups are for family, friends and co-workers of people who have a drinking problem. This group has helped me deal with my son's addiction to alcohol and drugs, and has educated me about the disease of addiction. The Journal of the American Medical Association defines alcoholism as "a primary, chronic disease characterized by impaired control over drinking, preoccupation with the drug alcohol, use of alcohol despite adverse consequences, and distortions in thinking."

1050

I went to a meeting of the Friends of Schizophrenics, as it was called then—it is now the Schizophrenia Society—in Welland shortly after my son was diagnosed. The doctor speaking was from the Hamilton Psychiatric Hospital. During the question period, I asked him—I remember specifically, and I quote—if he had "ever treated someone with schizophrenia and addiction to alcohol or drugs." His reply was—and I quote again, because it really stuck with me—that he had "but not successfully," because the treatment for addiction and alcoholism is a 12-step program, and people with schizophrenia do not like to be in groups.

So my son was sick. He had the disease of schizophrenia and the disease of addiction, and there was no treatment. Therefore, he lived at home with his stepfather and me for four or five years. He was put on ODSP, the Ontario disability support program, so his drugs were paid for. They ran, at that time, between \$800 and \$1,000 a month.

He was very attached to me. He would only go out of the house with me for quite a while. He would sleep all day and be up all night, pacing, pacing, pacing. He was upstairs, and we were trying to sleep downstairs. We were still working at the time, and it was difficult, to say the least.

He did share with me that he was angry all the time, so I got him into an anger management course. I took him and picked him up. That course did help. I could not find any counselling for him at that time, so he just went to a psychiatrist, and he ordered his medication and had a short talk. Thank goodness he liked his psychiatrist. They have gotten along well, and he has had the same one for 16 years. He is lucky in that respect, and so am I.

I paid for him to go to the YMCA. He always liked sports, and this helped him. He started to ride his bicycle again.

I paid for him to go to a martial arts school. The teacher—or sensei, in the martial arts world—was a friend of mine, and he accepted Jim. So did the group of people in his class. This really helped Jim. He had a place to go. He had a place to belong. He had people who accepted him. Jim got his black belt in kendo through that group. Now, if you don't know about martial arts, kendo is the Japanese art of fighting with bamboo swords. When he began, he said, and I quote, because again it stuck with me, "Mom, it's great. I get to hit somebody over the head with a stick and I don't get a penalty," because he played hockey all his life. But Jim was never violent. He was never violent in a psychosis, he was never violent at home, and he has never been violent to this day, in 16 years of having schizophrenia.

But mentally ill people are not accepted. There's a terrible stigma about being mentally ill. Educating the public about mental illness could help alleviate this stigma. Teachers should be educated; parents should be educated; ministers could be educated. Everyone should be educated, just like driving while impaired, just like stop-smoking education. Both these things have worked very well to educate everybody.

There is a program in the States called the clubhouse model. It's for people with mental illness, and it could be a room or rooms or it could be a building where people who are mentally ill can go and where they can be part of a group, where they can have things to do: games, crafts etc. They will have people to talk to. They could have tea, coffee, whatever. They would have things to be responsible for. They could be responsible for maintaining the grounds outside, for keeping the buildings clean, whatever they need to have in this organization. They take them on group outings etc. I could go on and on about what they do in these groups.

There is only one place that I know of, and it is Welland, that's like this. It is called Oak Centre Clubhouse, and it functions very well. But we have none in St. Catharines or Niagara Falls or anywhere else in the Niagara area, and I'm not sure if there are any others in Ontario. I belong to the Schizophrenia Society in St. Catharines-Niagara, and we have monthly meetings.

There are somewhere between 10 and 20 of our family members who come to our Schizophrenia Society meetings. Now, normally these are support meetings for the families of schizophrenics, but in our case our family members who are ill like to come to these meetings because they have nowhere else to go to meet and be with anybody. They are accepted even though we all know that they're mentally ill. It has been growing. Over the last five, six, seven years, more and more of our family members are coming. They come there and they share what medications they're on and they share that they're having hallucinations or delusions and what kind of medication worked. It's amazing, but there's nowhere else for them to go in St. Catharines except once a month to our meetings.

But we are just a volunteer organization in St. Catharines. We have no paid people in St. Catharines who work with these people. There are no programs for outings, for social events, for sports, for crafts, cycling; there's nothing. We need programs for our family members who have a mental health issue and are stable on their medication. We need education about drug and alcohol abuse in the schools and in the general public. We need education about mental illness to try to stop the stigma.

The other support we need is in help finding meaningful work. My son has had many jobs since he got sick, but he's afraid to tell his employer that he has a mental illness, let alone schizophrenia. If we could have government support to employers to hire people with mental illness issues, be it depression, manic depression, schizophrenia—or in my son's case, the final diagnosis that he has is that he has schizoaffective disorder, which means he has schizophrenia, anxiety and depression—all three. He's on medication for each one. But he cannot work full-time; he may not be able to work eight hours at first, or he may be one day a week or maybe only three or four hours at a time. Employers need to be educated about mental illness.

As I said before, the other people who need to be educated are police officers. Police officers need to be educated about how to deal with people who have a mental illness. My son Jim gets very anxious when he's around uniformed police officers. Last December, he was on his way to a hockey game—he was back playing hockey—when he came upon what he thought was an accident. So he tried to avoid it, but it turned out to be a RIDE check. So the uniformed police officer came running over, pounded on the window and told Jim to get out of the car. They gave him a roadside sobriety test and a breathalyser. He blew zero on the breathalyser, but he was shaking on the sobriety test. He told them he was on medication from a psychiatrist, but anyway they handcuffed him, took him to jail and put him in a cell. Then he had to give a urine sample in front of a female police officer. All this stress triggered an anxiety attack, so he failed some of the coordination tests. He was charged with impaired driving by drugs and then released to drive himself home at about 4 o'clock in the morning.

We got a legal aid lawyer, and we had to appear in court four times before we got the urinalysis test back,

which showed all of the psychiatric medication that he was on plus one kind of marijuana. The lawyer found a precedent case, and the crown attorney withdrew the charges. This just happened last week. His final court date will be this Friday. We don't really have to go, but I'm taking Jim and we're both going to thank the lawyer very much.

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My son has been lucky to:

- (1) have a nurse as a mother;
- (2) find a good psychiatrist who cares;
- (3) listen and take his medication always—now, he didn't always take it properly. One time I asked him why he was so sleepy, and he said, "Well, I didn't want to take those pills morning, noon and night, so I took all three in the morning." I said, "No, Jim, you can't do that. You have to spread it out over the day." So we've got things all straightened out now, and he has his medication in those blister packs where it says what time you're supposed to take them at;

- (4) have help from my husband and me to rent to own his house, so his ODSP rent goes toward owning his own house eventually, in 20 years or 25 years or so;

- (5) find a woman with almost the same diagnosis as he, and to be married to her for six years—quite happily, I must say;

- (6) find out that he loves gardening, and now he has a garden to work in;

- (7) have pets, which they've found is a very therapeutic thing for people with mental illness to have—he has two cats, which he loves very much;

- (8) have taken a course last September in Guelph, which I drove him to, to be a minor hockey official; he passed his test, and he refereed hockey games all winter long;

- (9) have a sister who helps him with his budget, with his money from ODSP;

- (10) have in-laws that help both him and his wife;

- (11) live in Ontario, where you get ODSP.

In closing, I'd like to say that we need education. We need education for children, parents, teachers, ministers, police officers and the public about drug and alcohol abuse and about mental illness. We need programs and clubhouse models. We need activities, sports, games, crafts etc. We need employment. We need help from the government so they can have part-time, graduated employment. The employers need to be educated, and the work needs to be meaningful. Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Jean. Thanks for telling your story. You've used up the whole 20 minutes to do it, unfortunately, but I think—

Ms. Jean Wiebe: I should have talked faster.

The Chair (Mr. Kevin Daniel Flynn): No, no. You talked at just the right pace. Do you know what? I'm not sure we need any questions. I think you got your point across very clearly.

Ms. Jean Wiebe: Thank you very much.

The Chair (Mr. Kevin Daniel Flynn): Thank you.

MARY ELLEN FREDERICK

The Chair (Mr. Kevin Daniel Flynn): Our next presenter is somebody I know very well as well. Mary Ellen Frederick, come on forward. Get yourself a clean glass, if you need one—there are some there—and some water. There you go. Good to see you again.

Ms. Mary Ellen Frederick: Good to see you, too.

The Chair (Mr. Kevin Daniel Flynn): Like everybody else in Ontario who's appearing before us, you get 20 minutes. You can use that any way you see fit. If there is any time left over for some questions of the committee, we'll try to get as many in as we can.

I'm not sure if you were here when I was saying that the mikes work better when you're about a foot away from them. Other than that, the time is all yours.

Ms. Mary Ellen Frederick: Okay, great. Thank you very much. Is that level good?

The Chair (Mr. Kevin Daniel Flynn): Perfect.

Ms. Mary Ellen Frederick: Okay. I'll also be reading my presentation. I wanted to thank all of you for giving me the opportunity to address the members of the Select Committee on Mental Health and Addictions.

My name is Mary Ellen Frederick, and I'm here with my husband, John, today. Our son, who is 27 years old, was diagnosed with paranoid schizophrenia three years ago. However, his mental health problems first emerged 11 years ago when he turned 17 years of age. It was at that time that our family embarked on a painful, frightening, confusing and isolated journey in search of answers, treatment and support for our son's increasingly escalating mental health and addiction problems. It is from those life experiences that I am making these recommendations. The following are key areas that a comprehensive mental health system needs to address.

Accurate diagnosis and treatment: It can take years for an individual to be accurately diagnosed, i.e., during the onset of psychosis. This delays effective and timely intervention in treatment and escalates the illness, the number of crises and the family challenges associated. There appears to be a critical shortage of psychiatrists and of professionally trained psychiatric support staff.

Stigma: Individuals and their families deal with mental health issues in isolation due to the stigma and ignorance surrounding this group of illnesses, creating even greater stress and, of course, delaying and often denying effective treatment. There needs to be a coordinated national, provincial and community education and information campaign utilizing the expertise of professional marketing to increase understanding and compassion within the general public for individuals and families battling these diseases.

Early intervention: Access to treatment should not be based on crisis and an escalation of mental illness; it should be through early intervention before illness becomes debilitating and life-threatening. There needs to be intensive, targeted education of professionals—i.e., teachers, police, general practitioners and HR staff of employers—on how, when and where to refer individuals

for treatment. Once referred, access to professional psychiatric treatment and intervention needs to be immediate. Lengthy waiting lists result in an escalation in the severity of the client's mental illness, making treatment more difficult and contributing to the erosion of the client's family and friend support systems.

Currently, it would appear the only expedient way to receive treatment in both Ontario and Quebec is through emergency rooms. While living at home, our son called the crisis line several times when feeling suicidal and was brought to the hospital by police and then admitted to the psychiatric ward of our local hospital on a short-term basis. After a brief stay in hospital and with very little counselling or psychiatric diagnosis, he was put on powerful anti-psychotic medicines which were monitored by very brief 15-minute visits to a hospital day clinic. After discharge from the hospital, our son received virtually no psychiatric follow-up counselling or referral to any community-based programs.

Treatment focus: In general, mental health services, including professional treatment and community support services, are underfunded and are not available to individuals when needed. Access to treatment involves long waiting lists after individuals are assessed and referrals are made. Increased funding is required to train more professionals to provide treatment in the system, i.e., psychiatrists, psychologists, psychiatric nurses. We need to develop effective, multidisciplinary outreach community treatment teams.

Effective treatment requires much more collaboration between family, treatment teams, employers and educators. There is now a focus on early intervention, particularly for the high school population, which is to be applauded. However, there are many people in their 20s, their 30s and beyond who were diagnosed much later. There need to be resources and effective treatment strategies developed for this population as well.

Treatment focus on the whole family, not just the client: Counselling should include support for spouses, children or parents, if the clients are still living at home. Family needs to be a part of the treatment plan, especially before, during and after hospitalization. Families should be included in some of the therapy sessions and involved in discharge planning.

Privacy act: The privacy act should be reviewed and special provisions built into it for individuals and their families who are dealing with serious mental illness. Currently, in the name of privacy, sensitive diagnostic information is not shared with a client's family, so the counsellors speak to the client, not family, which can result in anger and isolation and create a very negative environment when the client returns home. This is completely counterproductive, as it is the family that the client depends on for long-term support.

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Concrete support services for spouse and children: Babysitting and transportation assistance should be available so that spouses can visit loved ones in the hospital and have free time to do necessary errands like groceries,

banking, etc. Spouses at home shoulder all of the parental and living responsibility while a client is in the hospital.

Young children: Currently there appears to be no focus whatsoever on support for young children in families with one or more parent battling serious mental illness. Children suffer guilt and separation anxiety when a parent is hospitalized long-term. There is no support for them or the spouse. Clients and partners need parental coaching.

Medication issues: Treatment is too focused solely on medication. Once a client is stabilized, there needs to be more emphasis on life skills training and support for living purposefully in the community. Clients need step-by-step support towards re-engaging in family and community life, i.e. job preparation, training, re-education, parenting courses, skills development, specific individual retraining to get back drivers' licences, fitness re-engagement in healthy physical activities.

Medication education: Clients and families should be given full disclosure on the medication that a client is taking and its side effects, how they interact with other medication and food, etc. Excessive weight gain from many medications causes serious health and also mental health issues. People are depressed about their body image and the inability to do sports, work out—things that individuals were able to do before the weight gain. Currently, psychiatrists do not appear to address the serious physical side effects of prolonged usage of prescriptions for serious illness like psychosis.

Lack of coordinated treatment for concurrent disorders: In most cases, treatment for addiction and mental health operate in silos—different organizations, different philosophies, different counsellors—all working with one client who is suffering from both mental health and addiction. Concurrent disorders are non-divisible. They are intertwined and interactive, and the individual needs a holistic treatment approach in order to be effectively treated. The waiting list for any publicly funded facility offering treatment for concurrent disorders is unacceptably long. Treatment is only immediately available if payment is made privately, but the cost is prohibitive for most families.

Criminalization of mental health: Criminalization of persons suffering from mental health problems appears to be related to the current high level of negative stigma and ignorance in our country towards mental health. It is most prevalent with paranoid schizophrenia and the sensational coverage by newspapers when someone suffering from this disorder is involved in violent crime. This stigma permeates even the helping professions. A case in point: Our son voluntarily went to the emergency ward at the Gatineau hospital in Quebec and asked to be admitted when he felt his illness was out of control. After he was hospitalized for a week or so and had been sharing his paranoia, his conspiracy theories and violent thoughts with the psychiatrist in this hospital, the psychiatrist called the police and had him removed from the psychiatric ward and jailed. When our son appeared in court, the judge questioned why he had been arrested and referred our son back to the mental health system. This

was a terrifying experience for our son, but ironically, by entering into and becoming engaged in the court system and, ultimately, the mental health court system of Quebec, the result was his receiving both psychiatric and outreach community counselling that is now monitored by the mental health court. This was a negative, a convoluted and a resource-wasting path to receive the treatment he required and should have received in the first place after he self-admitted to the hospital.

Universal health plan: non-existent. Provincial borders are really treatment barriers.

Disability allowance and benefits: There is a great disparity between services and treatment available from province to province. Disability allowances are in fact welfare benefits, and those battling mental illness and living on this allowance live in poverty. Their families and children need additional support—i.e. daycare, transportation and school nutrition programs—so that their children are raised in a healthier, supportive environment.

Provincial borders are treatment barriers. Our son lives in a common-law relationship in Gatineau, Quebec, so he now has a Quebec health card. He speaks no French. He is in close geographic proximity to Ottawa and all of the English services for mental health, but because he resides in Quebec and carries a Quebec health card, he can only receive health care services there. When he was being assessed by the psychiatrist for the courts, the psychiatrist had to have an interpreter. The inability to speak to a professional in your own language is a severe limitation to treatment. Our son cannot participate in any support groups in Quebec due to the language barrier. If we are to have an effective mental health strategy, provincial borders should not act as barriers to effective treatment. Clients and their families should be able to access the best treatment anywhere in our country.

Research: None of the above recommendations can be operationalized effectively and efficiently without well-organized and well-funded long-term and short-term research. Research is needed into the etiology of mental illness, genetics, environment, nutrition etc. to enable more accurate diagnosis and treatment. Research is needed on medications, developing new, safer, more effective meds and researching current medications more thoroughly—their short-term and their long-term effects on the individual's mental and physical health. Research is needed on treatment modalities: what works, what doesn't. The current need is so great that treatments need to be introduced based on anecdotal evidence, but eventually treatment concepts—i.e., community outreach teams and clubhouses—need their effectiveness evaluated by evidence-based research. The Canadian Cancer Society Research Institute provides a good existing model to replicate and improve upon for research into the mental health field.

That concludes my presentation. I don't know if there's time left for any questions.

The Chair (Mr. Kevin Daniel Flynn): There is; there's actually about five minutes, and I think it's Sylvia's turn to go first.

Ms. Sylvia Jones: Thank you, Mary Ellen. I have one question. You mentioned that your son is 27—

Ms. Mary Ellen Frederick: Yes.

Ms. Sylvia Jones: —and he was only diagnosed two years ago?

Ms. Mary Ellen Frederick: Three years ago.

Ms. Sylvia Jones: Three years ago. Why did it take so long? What did you see as the barrier?

Ms. Mary Ellen Frederick: From everything that I understand, psychosis increases in severity over time. When he first started showing symptoms, I had a colleague who was a psychologist, so we engaged him. For over a three-year period, he provided private counselling for our son. He thought he was dealing with an anxiety disorder, and my son received a lot of behaviour modification counselling. That was helpful in triggers and because he was suicidal. However, at the same time he was increasingly abusing and becoming addicted to alcohol and drugs, and became particularly addicted to marijuana. The addiction problem became the one that we as a family were more concerned about dealing with. It was out of control. The psychologist could not deal with the addiction, so Tim ended up in a detox centre. He ended up going to the Renascent centre in Toronto for addiction treatment, which he dropped out of. With the help of the psychologist, we got him in to a counsellor at CAMH and it was around that time he self-admitted to our local hospital and started receiving medication. At that time, the psychiatrist there said he wasn't sure whether he was dealing with psychosis or whether it was the short-term effects of prolonged use of marijuana, which he felt were the same, and until he was off of marijuana for a year, he felt he couldn't be properly diagnosed. However, he was put on anti-psychotic medicine at that time. It was an evolving situation, so it was not until he went to Quebec and entered into the system there that he was diagnosed as paranoid schizophrenic.

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The Chair (Mr. Kevin Daniel Flynn): France?

M^{me} France Gélinas: Just a quick question, and it's personal so you don't have to answer if you don't feel comfortable, but does your son work?

Ms. Mary Ellen Frederick: No. He has been in and out of the hospital for stays in Quebec. He has two small children, one his partner had previously, so a four-and-a-half-year-old and a two-and-a-half-year-old—granddaughters—that they're caring for. His medications are being monitored by a psychiatrist. He does have an outreach worker but at this point in time he's not able to work, no.

M^{me} France Gélinas: I realize the language barrier and the added difficulty that brings. Aside from his spouse, does he have any social support? If he doesn't work, what are his—

Ms. Mary Ellen Frederick: His only social support would be the friends that his spouse has, because his spouse is from that area, and she has a small amount of family. His main social support would be the outreach worker he sees. He's quite isolated because in the hous-

ing complex where he lives the language that is spoken is French.

The Chair (Mr. Kevin Daniel Flynn): Maria, a very short question?

Mrs. Maria Van Bommel: Very quickly, you talked about programs for children of mentally ill people and you mentioned you have two granddaughters.

Ms. Mary Ellen Frederick: I do.

Mrs. Maria Van Bommel: Are they getting any kind of programming in Quebec? You brought that issue up, so I'm just kind of wondering—

Ms. Mary Ellen Frederick: Yes, because I don't see a focus—the treatment that my son is getting is focused on him, so his family is not a part of that. So if he's in a hospital for six weeks, as he was last summer, he receives treatment; they don't. His spouse does have a counsellor to help with child rearing for our older granddaughter. We have provided support for her also to be in daycare, ourselves personally. But there is no focus whatsoever, in terms of his illness, on engaging the family and dealing with the family unit, and I think that's very important. Whether a person battling mental illness is in their original family, living with their parents, or whether they're in a marriage situation or whether they're living independently on their own, most of the time the support in their life is coming from their families, and there needs to be communication in the treatment process with them and support.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Mary Ellen. Thank you very much for coming today. We really appreciate it. Thank you, John.

JUDITH FINK

The Chair (Mr. Kevin Daniel Flynn): Our next speaker after Mary Ellen is Judith Fink. Judith, make yourself comfortable; grab yourself a clean glass. I think you've been here for the other presentations.

Interjection.

The Chair (Mr. Kevin Daniel Flynn): That's right; we need the seventh-inning stretch here.

You've been here for, I think, a few of the presentations, so you know you have 20 minutes. You can use that any way you see fit. If you can leave some time at the end, that'd be great; other than that, it's all yours.

Ms. Judith Fink: Thank you so much. It's a pleasure, and I truly appreciate being able to present to this all-party committee.

I'd like you to just join me for a minute in imagining something. Think of a young child; it could be your own child, grandchild, a niece or a nephew. Which words describe him? Is he curious, eager, affectionate, playful? Imagine sitting by the bedside of this child while he sleeps, knowing that he has a high fever, thinking about the recovery from his illness. The fever breaks, he opens his eyes and he looks at you. There is some recognition in his eyes, but he looks away. You speak to him, and he responds with a one-word answer, no interest in what you're saying. You reach out to him, but he doesn't want

to be touched. No hugs, no smiles, no giggles, no laughter—that's what it's like to be a parent with a child who has schizophrenia.

I've divided my presentation into three sections: recognition of mental illness, support for the mentally ill, and promoting recovery. And I'm asking you as representatives of the people of the province of Ontario to improve health care for people with mental illness, to educate the public and professionals, and to provide service and information in all Ontario communities. You will notice I live in Newmarket, but I've had experience in Toronto, York region and Peterborough in dealing with my son's illness.

My son was a bright, normal, social child. He did well in school, participated in extracurricular activities and, when he was 21, moved to Peterborough to attend Trent University. He was very successful in his summer jobs, but in 1997 began to skip classes and be more involved with substances like alcohol and marijuana. He broke up with his girlfriend, or she broke up with him, and the onset of schizophrenia—we're not sure if there was any kind of cause-and-effect relationship. They just seemed to happen around the same time, which made it, of course, very difficult to recognize whether this was a normal response to a breakup or the onset of a mental illness. Anyway, the next couple of years he lived quite an isolated life, and in 1999 he recognized that he needed to make some changes. He left Peterborough and moved back to Toronto.

He could not find housing on his own, something that he'd been able to do previously. He could not hold a job for more than a couple of weeks, something he had been able to do previously. We realized it was a serious problem. We consulted our family doctor, and she was quite sure from speaking to him and observing his behaviour that he had developed schizophrenia. He absolutely resisted getting any kind of treatment. He was belligerent in psychiatrists' offices and absolutely refused medication. We know now that's part of the paranoia that accompanies the disorder.

We had to take on basic responsibilities, his dad and I, to find him a place to live; we paid for his rent and we gave him a living allowance. He agreed to work with a talk therapy psychiatrist for a couple of years, but that was very limited in its effectiveness. We struggled and struggled to get him to go to an appointment with a psychiatrist, and eventually he gave in and had a psychiatric assessment. The follow-up appointment was scheduled, and my son and his dad showed up for the appointment and were told that the appointment had to be cancelled because his psychiatrist had been called away on an emergency. At that point my son became incredibly angered and totally rejected all medical help.

What did we learn? We learned we need to recognize the symptoms of schizophrenia in early adulthood. We need to remove the stigma that's associated with mental illness. We need to overcome barriers to actually connect a patient to doctors for diagnosis. We need improvement in the general education through secondary school pro-

grams. The onset of schizophrenia, as you probably know by now, is usually between the ages of 14 and 25. We need to support media education which is accurate, and we need to recognize that with paranoia and a loss of reality, it is extremely difficult for the patient to advocate for himself.

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Please improve health care for people with mental illness. Shorten the wait time for psychiatric assessments. Encourage psychiatrists to work as part of a mental health team. If the original psychiatrist is unable to do the follow-up visit, there should be someone present who can take over and provide the services that are needed immediately. Promote psychiatry as a highly respected option for physicians. We absolutely need more psychiatrists in our province.

Educate the public and professionals. Initiate mental health issues education as part of the curriculum for students at the intermediate and secondary school level. Make mental health information part of teacher professional development for secondary school educators. Provide school guidance counsellors with relevant information regarding recognizing mental illness. Encourage teachers to refer students to guidance counsellors to address the need for formal diagnosis.

Please provide education, service and information in all of our communities. Up-to-date information about mental health services should be available through a website with links. Institute 211 access to social services throughout the province. This is something I learned about last week. I had no idea; we don't have it in Newmarket. It's available other places; 24/7, you dial 211 and they are able to direct you to social services to take care of the issues that you're having. It's not available throughout the province. Publish mental health crisis phone numbers with other emergency numbers in telephone directories.

The second part of my presentation deals with support for the mentally ill. We continued to try to get our son to work with a different psychiatrist and to take medication, and after he rejected the offer from the Clarke to try medication for a short period of time, we made the very difficult decision to stop our financial support. We gave him some time to find some income, and then we stopped paying his rent as well. Of course, he was evicted from his apartment, by the police. We packed his belongings and put them into storage. This was an incredibly difficult thing—I mean, if we weren't weeping constantly, we were certainly brimming with tears—to pack up, clean up and move his things into storage, not knowing where he was going to go or what he was going to do.

He left Toronto, went back to Peterborough and moved in with a friend, got a job in a café, phoned his dad. The job didn't last, neither did the housing circumstances, and the next four years were extremely difficult. We could see that he was having delusions. He had extreme trouble with relationships and several jobs within the next few months. When things weren't working out for him in Peterborough, he took off for the

family cottage. During the winter of 2004-05, he isolated himself there. We were very concerned for his welfare—how he would get food, how he would provide himself with heat and his inability to make judgments that were, we believed, essential. Occasionally, he would answer the telephone. One Christmas I went out and walked into the cottage; he wasn't home. I just left a bag of goodies on the doorknob.

In the spring, we moved him to an apartment in downtown Peterborough. He needed help from his parents to find the apartment and to make the move. He applied for ODSP finally in April 2005. He had refused previously because he denied that he had any mental health issues, but he was now physically injured, and so it was okay to apply for ODSP because it was a physical issue, not a mental issue. Regardless, it took 10 months—until January—for him to receive his first cheque. During this entire period there was tremendous deterioration—disconnection from reality, isolation, delusions, hallucinations and paranoia. In May 2007, he was evicted from his next apartment, this time for security reasons.

During the period of time when he was ill, we came to understand that survival is very complicated and difficult for a person with untreated schizophrenia. Family members require counselling to determine how and when to help the loved one, where to find services and how to preserve their own physical, emotional and mental health. My son suggested that we need to support food banks. That was one thing that was incredibly important to him: knowing that he could go to a food bank when necessary. We need to improve our financial support in housing through ODSP. We need to educate police and the justice personnel so that they master required skills and have the knowledge to interact with a mentally ill person.

So my recommendations are:

Educate the public and professionals. Provide training and more education for police and justice personnel in dealing with people who are mentally ill.

Provide service and information in communities. Make programs like the York region CMHA support group for families and caregivers available and accessible. Support and work with food banks to sustain individuals in need. Respect the need for privacy, but provide information to food bank personnel so that they can monitor, recommend and initiate contact with services when appropriate.

Make some modifications to ODSP by linking the recipients with caseworkers who are trained, have time and knowledge, and can refer their clients to appropriate services.

The next part of my presentation is the happy part: promoting recovery. After being evicted from his apartment in Peterborough—and let me remind you again that this act of packing the belongings, washing the dishes, moving everything into storage and not knowing what's going to happen is very distressing for the families. You have no idea what tomorrow is going to bring. You just know the police have escorted your son away again.

Police officers took him to hospital. Fortunately, he had a crisis worker with him who stayed with him, and

after several hours he was finally admitted. The psychiatrist was on duty, which is not always the case. In a town like Peterborough, the psychiatrist—the psychiatrist—splits his time among at least two jurisdictions. Zyprexa was prescribed. He took it without resistance, and within days there was a significant change. He was discharged after two weeks, and received excellent help from his CMHA case worker.

He found an apartment on his own, continued to keep his appointments, and when the noise downstairs got to be unbelievable, he organized his own move to a different apartment. In September 2008, he went back to Trent, took a two-part computer course and did quite well. Now, as of the beginning of this month, he's attending the concurrent issues residential program in Penetanguishene, called Georgianwood. If you don't know about that, I'd like to tell you about it.

So in order to promote recovery, we need to:

- recognize that schizophrenia can be treated with medication;

- realize that there are many people in hospital admission staff who do not recognize mental illness or have training to deal with a person in crisis;

- understand that an independent, productive life is possible;

- provide support through existing community health programs; and

- expand and create special residential programs to help establish a normal lifestyle for a person in recovery.

Please, once again, improve health care for people with mental illness. Educate nurses and admission staff to respect the family, police or social workers who bring a person to hospital. Teach hospital staff to recognize the volatility of mental illness. A mentally ill person can pretend, for a short period of time, to need absolutely no help. Initiate a reasonable period of time for observation before sending a mentally ill person away.

Provide services and information in the community about recovery support programs. Tell the individuals receiving treatment, medical personnel, counsellors and families what is available, and maintain and update websites with current information.

For recovery support programs, work through community centres, libraries, adult education centres and the Y to initiate programs for those in recovery. Create provincial initiatives to hire those in recovery on a part-time, temporary basis, with supervision and support from mental health professionals. And, of course, involve the healed person in the recovery process, and perhaps even use them as mentors to others who are ready to build new and healthy lives.

To summarize, please improve health care, educate the public and professionals, provide service and information to the communities, and hopefully we will see more curious, eager, affectionate and joyful people in our province.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Judith. You mentioned Georgianwood?

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Ms. Judith Fink: Yes.

The Chair (Mr. Kevin Daniel Flynn): And you said that, if we asked you, you'd tell us about it. So why don't I start asking you, and then we'll—

Ms. Judith Fink: I found out about this through the York region support group for families and caregivers. Our team leader invited a young man who'd been at Georgianwood. It's a concurrent program and it's run at the mental health facility of Penetanguishene. It is for people with substance abuse and mental health disorders. It is a totally concurrent program. You must be off substances for a period of 72 hours before they'll admit you.

We were fortunate. Our son finished his courses in May and was accepted in June. He had one week from the phone call that came through to be ready to go, and it was great. I said to him, "I can't believe I'm washing your dishes and organizing your place and you're here, you're well and you're going to get help, that we're not taking your stuff into storage and the police aren't at the door."

The program is very comprehensive. It includes physical activity, eight different counselling support groups, some dealing with substance, some dealing with employment, some dealing with individual counselling, some dealing with group counselling. There is an Alcoholics Anonymous meeting that takes place. There are physical education resources that are shared with the correctional facility. There's a pool, tennis courts. It's located on a beautiful site right on Georgian Bay. The intake is 12.

The Chair (Mr. Kevin Daniel Flynn): Twelve beds?

Ms. Judith Fink: Twelve people for a three-month program, but it is comprehensive, if my son's experience is anything like that of the young man who came to talk to us or the way the social worker spoke to me when I was there last Tuesday.

The Chair (Mr. Kevin Daniel Flynn): Okay, and it's funded by OHIP?

Ms. Judith Fink: Yes.

The Chair (Mr. Kevin Daniel Flynn): That's wonderful.

Ms. Judith Fink: That's to the best of my knowledge. It's not costing us anything.

The Chair (Mr. Kevin Daniel Flynn): Thank you. Let's start with France. We've probably got time for maybe two questions.

Ms. Judith Fink: Good. I got it down to 18 minutes.

The Chair (Mr. Kevin Daniel Flynn): One question each.

Ms. Judith Fink: I've been talking faster every day.

The Chair (Mr. Kevin Daniel Flynn): No, no, you've done a good job.

M^{me} France Gélinas: We've had a few family members come and talk to us, and listening, there's this great divide as to family members wanting their loved one to get treatment and often the person with mental health refusing treatment. This is something we see in cancer treatment. There are people who have been diagnosed with cancer who refuse treatment, there are severely diabetic people who refuse treatment and there are quite a

number of seriously mentally ill people who refuse treatment. Your son went through this phase for a long time and then finally accepted it. Do you have recommendations for us for that period of time where he refused treatment? How do you balance the right of a person to refuse cancer treatment etc., as well as mental health treatment, versus the good that can come of it?

Ms. Judith Fink: It's a very difficult issue, of course, and that's why the family counselling is extremely important, because, of course, the parents want their child, or the sister wants the brother, to receive treatment and take medication, and it's almost impossible to do that.

The people who came to the groups that I attended through the CMHA program were facing these issues of denial. I don't think our son ever would have gotten help if we hadn't pulled the plug on the finances. The reality has to be so bad that they have to want treatment. One of the things that the talk therapist said was, "There's no point in forcing him to take medication; he'll just go off it anyway," which is a major issue.

The family needs to know that they have to step back. One of the social workers said to us, "Don't forget the three Cs: You didn't cause it, you can't cure it and you can't control it." So the burden has to be on the individual. That's why I brought up this issue of food banks. During that period of time when a person is unmedicated and mentally ill, they need to survive.

My son did have a brush with the justice system, which turned out to be wonderful for us because he had an excellent probation officer who essentially said to him, "Go for a psychiatric assessment or we're putting you in jail. Meet with your caseworker or we're putting you in jail." He wasn't belligerent; he was very helpful. For some wonderful reason, he was able to stay in touch with myself and my son's dad on a monthly basis. The link through the justice system, through the mental health system in Peterborough at that time—they were able to be in touch with each other. So when we did have this issue of taking him to the hospital at the end, the mental health team and the justice team were on site and we got excellent help at that point, but—

The Chair (Mr. Kevin Daniel Flynn): Thank you, Judith. I'm going to have to end it there, unfortunately, but I think you got your point across very clearly at the end. So thank you for coming today.

Ms. Judith Fink: Thank you for instituting this inquiry.

HALDIMAND-NORFOLK RESOURCE CENTRE

The Chair (Mr. Kevin Daniel Flynn): Our final presenter before we break for lunch is the Haldimand-Norfolk Resource Centre. Susan Roach is with us. Susan, come forward. You can probably find a clean glass there somewhere if you need one, and, like everybody else, you've got 20 minutes.

Ms. Susan Roach: Okay, thank you.

I'm a daughter, a friend, a program manager, a community volunteer, a colleague, a university graduate, a life skill coach and a suicide intervention trainer. I enjoy photography, I love to read and I bowl. And I am a person living with a serious and persistent mental illness.

Thank you for this opportunity to present today. I am Susan Roach. I'm the program manager of the Haldimand-Norfolk Resource Centre. We are a mental health drop-in program run by and for people living with a mental illness. We have a mandate to provide social recreation, education, peer support and advocacy. We are a program of Community Addiction and Mental Health Services of Haldimand and Norfolk. We are considered to be a consumer-survivor initiative, one of 61 similar programs across the province of Ontario.

I've taken the time to tell all of this about myself today because some of the greatest barriers for people living with mental illness, in treatment, in services and in our community, are the assumptions that people make about who we are and what we are capable of. Illness becomes the predominant way in which we are viewed by others, and services and supports narrowly assume that as long as they treat the symptoms of our illnesses, they have provided adequate care for our mental illness or our addiction.

Clearly, we must have access to doctors and psychiatrists, there must be an adequate number of hospital beds and programs dedicated to providing mental health and addiction treatment, and programs must be accessible without long waiting lists and without barriers and numerous hoops to jump through in order to get those services. These represent the elements of the medical model of treatment that need to be sustained, improved and enhanced. However, we must look at how we deliver these services and begin to recognize that these services alone do not provide all that is required in order for an individual to recover.

Recovery is not some elusive concept, and it's not founded on the premise of a total absence of symptoms. Rather, it is based on the principle that hope and meaningful life are possible despite the mental illness and/or the addiction. Recovery is a process by which the individual living with mental illness recovers self-esteem, dreams, self-worth, pride, choice, dignity and meaning. Recovery is a personal process, but it can either be supported and encouraged or undermined by the very design, development and delivery of our health care and social service programs.

Our system of care must first and foremost believe in, invest in and proceed as if recovery is always possible, because nothing will extinguish hope faster than an implied or direct message that while we may be able to achieve some symptom relief, thinking that we will ever achieve anything further is just a pipe dream.

1150

Toward recovery, we must be provided input through the whole process of our care and in the designing and development of programs and services. Systems and programs need to be person-centred. The system must

begin to challenge us and empower us, not coddle us and do for us. We are capable, and the system needs to proceed as if we are, not as if we are not. Opportunities for recovery are enhanced when we are viewed as whole individuals, not just as a cluster of symptoms. Our culture, spirituality, meaningful activity, work, socialization and education are all components that need to be addressed to support our recovery.

Recovery is supported when the system works from a position of recognizing our strengths rather than focusing on deficits and weaknesses. Recovery is supported when those important to us are engaged in the process. Recovery is supported when services are available within our own communities and when opportunities to be engaged and involved in the community are provided and supported.

I want to take a few minutes to share with you comments offered by others living with mental illness who attend the resource centre where I work. We asked our members to share with us one important message that they believe the community needs to learn about mental illness. Some of their responses are as follows:

"People with mental illness can live a productive life and be as important to the community as someone who doesn't have an illness."

"We are capable of parenting, employment, self care and basically having a 'normal' life," just like anyone else.

"That people with mental illness are not lazy, sitting on their butts, smoking and drinking coffee. They lead very productive lives in the community," when given the opportunity.

"That people with mental illness can recover."

I've included these particular statements because we need to be aware that, even in 2009, we still have people living with a mental illness who every day feel misunderstood, devalued, minimized and stigmatized. They know that they can and do have much to offer, that they are not violent, stupid, lazy or non-contributing. But how long does that hope and belief remain alive if it is not nurtured, supported and endorsed? How do we continue to believe when so much energy and personal resources are needed to be put into just sustaining ourselves and surviving?

Mr. Kirby raised an interesting point when he presented to this committee: that there is no single point of responsibility for providing mental health and addiction services. Mental illness and addiction will never be fully addressed if we focus only on having doctors, hospital beds or community clinical services. Yes, they must be present and they must be recovery-focused, and the recovery focus begins with accepting that the majority of challenges that we face will begin when we are discharged from hospital or when we leave the clinician's office—basically, when life begins.

The Ministry of Health and Long-Term Care, the Ministry of Community and Social Services, the Ministry of Transportation, the Ministry of Community Safety and Correctional Services and the Ministry of Municipal

Affairs and Housing need to begin to work together to develop comprehensive solutions to the life challenges, the barriers that are inherent in their programs, which serve to undermine—and which can thwart—recovery. The time has come to end the "Oh, yeah, that's an issue, but it's not our responsibility." Everyone has historically been very good at passing off responsibility, leaving individuals with incomplete and fragmented services. Pieces of some programs are built on a foundation, which are generally assumptions, that the pieces are in place somewhere else. We need to make concepts like "seamlessness" and "comprehensive" a reality.

Again, I'd like to share with you the stories, challenges and experiences of the members from the centre. One of the programs of the Ministry of Community and Social Services is Ontario disability. It's there, supposedly, to provide financial help for people with disabilities who are in need, and it's supposed to help pay for living expenses like food and housing. Over 90% of our membership at the resource centre is on ODSP. While we appreciate that we have a system which financially supports those with disabilities, the current system is fraught with difficulties that begin right at the application stage.

Unfortunately, it's generally accepted by those who apply for benefits that no one will be accepted in their first application for ODSP. Virtually all will need to attend a tribunal hearing before they will finally be approved to receive benefits. One gentleman needed to attend seven hearings before he was finally approved to receive support and required legal counsel at the tribunal hearing in order to make that a reality. This can result in an elapsed time of three to five years between when people apply and when they are finally accepted to receive ODSP benefits. One member expressed that you are automatically suspect if your application is for mental health versus physical health problems.

Once in receipt of ODSP, the financial support an individual receives falls far below the poverty line. Disabled people in Ontario are falling more than \$5,000 below the poverty line. Benefits are based on an allotment for housing set at \$454 per month. I would challenge anyone to try to find housing anywhere in this province for \$454 a month. Unfortunately, in part, it's based on the premise that individuals who are on ODSP are going to be eligible for subsidized or geared-to-income housing. Unfortunately, the reality of that system, as it's currently operated by the Ministry of Municipal Affairs and Housing, is that the waiting list can be in excess of two years to receive an offer of housing, and where, in the area I come from, Haldimand-Norfolk—and we have absolutely no public transit—offers of housing may in the end be for an apartment that's far removed from your own community and away from all supports and resources. Turning down a housing offer can cause you to lose your place on the waiting list.

Additionally, if you're on benefits because you have a disability and by chance you get sick and are hospitalized, the potential exists to have your benefits suspended.

You will then only receive \$112 a month, which is considered a personal needs allowance, and an individual may lose their housing. Then all your belongings have to go into storage, and if you've been in subsidized housing, you can't get reconsidered for housing until you can pay the back debt that you owe. If you're only getting a thousand dollars a month, trying to clear a back debt in order to put yourself back into a position of eligibility is extremely difficult.

More than 40% of our members currently report that they are paying more than half of their income on rent, with many of those also paying utilities. Members are left with an almost daily challenge of deciding what will get paid and what, for the moment, has priority. One member was recently confronted with making the decision whether her child's over-the-counter medication or food would receive priority.

Although indicated as required by the physician, over-the-counter meds are not covered under the drug benefit, and individuals who, in addition to their mental health diagnosis, may also be attending to a range of physical issues are often faced with stretching an already over-extended budget in order to meet those needs.

Further changes to ODSP have made the process of obtaining additional funding for special diet needs difficult to access and far below the previous rates allotted to meet these needs. One individual reported that where previously they received \$52 per month to assist with their medical dietary needs, this amount was cut to just \$10 per month—although, as you can appreciate, the cost of food has only risen, it has not gone down.

1200

As I've already mentioned, Haldimand-Norfolk is a community without any public transportation. Our program serves a community equivalent, geographically, to half the size of Prince Edward Island. Members are scattered throughout this rural area. Although peer support programs such as ours are identified by the Ministry of Health as a best practice, which means they contribute to an individual's overall health, well-being and quality of life, it's not equally recognized by the Ministry of Community and Social Services, which is in a position to provide for transportation. Although medical transportation can be covered by ODSP if an individual is going to a peer-run AA or NA meeting, it's not covered if they're coming to a peer-run mental health meeting. Daily, we face the challenge of how to enable people to even get to the centre and access the supports that we have to offer. While we do operate two vehicles, these are not funded in our base Ministry of Health budget, because transportation is not deemed to be a health issue. So we fundraise to cover vehicle operations. Individuals struggle to get to the centre for support, but transportation as a health issue extends even further for the majority of our members.

We recently did a survey and 41% of our members reported that their family doctor was not located in the same community in which they themselves resided, and that, in addition, 65% have further need to travel to attend to see a medical specialist. The significant

outcome of this survey that is of great concern to us is that 38% of the individuals we surveyed indicated that, based solely on a lack of transportation, they had missed a scheduled medical appointment, and that, as an outcome, had ended up using the services of either a walk-in clinic or the emergency room in order to attend to their medical needs. Additionally, it should be noted that for those few who may be able to operate a vehicle while on ODSP, ODSP approves a reimbursement rate of only 18 cents per kilometre for transportation.

Individuals with a serious and persistent mental illness continue to want to be engaged in meaningful activity. This may mean attending programs such as the centre, volunteering in the community or working. Participation can be negatively impacted by a lack of available transportation, lack of opportunities, program design and/or stigma.

Individuals have lost jobs when evidence of their mental illness became known to the employer. One individual lost their job of nine years when they were diagnosed, as concerns were raised suddenly about their ability to be productive. Others have had their opportunity for employment compromised when their police record check disclosed Mental Health Act information. One individual, where the police had been involved to transport them to hospital when they were suicidal, had noted on their police record check that they were "the subject of a mental health investigation." Embarrassment and fear of public scrutiny kept that individual from pursuing the position because they didn't want to hand their police record check to their potential employer. Others have sought and begun work under the revised ODSP work incentive program, which offers individuals \$100 per month as a supplement. However, for one individual who did that, they got the \$100 benefit and they lost the \$160 transportation allowance that they had originally received in order to get to work.

The Chair (Mr. Kevin Daniel Flynn): You have about 30 seconds left, if you just want to summarize.

Ms. Susan Roach: Basically, we have challenges in running the program as well. We are woefully, as consumer initiatives, underfunded. We have an operating budget of around \$200,000 per year, and yet last month alone we provided 2,222 hours of member support between our two sites in Dunnville and Simcoe.

The Chair (Mr. Kevin Daniel Flynn): Thanks for being here today, and I didn't mean to cut you off, but we are trying to be fair to everybody, and I think we got your point.

Ms. Susan Roach: Can I just finish my last sentence on here?

The Chair (Mr. Kevin Daniel Flynn): Sure.

Ms. Susan Roach: So what is it that we do? Consider the response of one member, who said, "Before I found this place, I was on a suicide mission. Now I have reason to be alive."

The Chair (Mr. Kevin Daniel Flynn): That's a great way to end. Thank you.

Ms. Susan Roach: I have left you with a copy of our most recent newsletter, for anyone who would like to take a look at it. I also did provide—

Interjection.

Ms. Susan Roach: Yes, that's the newsletter you're holding up. I also provided a copy of the transportation survey that we did. My final report is not yet really final, but it should give you a good overview.

The Chair (Mr. Kevin Daniel Flynn): Perfect. Thank you very much for coming today.

For the committee members, checkout of the hotel is at 1 o'clock. The lunch is at Windows on King, which is above the lobby, next to where you had breakfast this morning. The luggage needs to be on the bus at 4. We're going to eat here, and we're going to leave here just before 6. Okay?

We're adjourned.

The committee recessed from 1206 to 1332.

CARLA

The Chair (Mr. Kevin Daniel Flynn): Okay, ladies and gentlemen, if we can call to order for the afternoon, I'm sure we'll be joined in progress by France in a few minutes. Our first presenter of the afternoon is Carla, if you'd like to come forward. Make yourself comfortable. As I've explained as we've been travelling throughout Ontario, everybody has been taking 20 minutes and they've been using that as they see fit. So if you want to make that all presentation, that's fine; if you want to leave something at the end, that's fine too.

Carla: Thank you for this opportunity to speak before you today. My name is Carla. I am a resident of Burlington, Ontario, where I live with my husband of 20 years. I am here as the sister of a 46-year-old man affected by serious mental illness.

Our family first became aware of my brother's illness in 1991 when he was 28 years old. A graduate of McGill University, my brother was in the early stages of what appeared to be a promising career in the field of computers. He had been married for two years, had purchased a home in Burlington and barely one month earlier had welcomed an infant son into his life.

Our parents, who emigrated from Italy over 30 years earlier and who raised us in a small French-speaking community in northern Quebec, had recently retired and moved to Burlington. I will never forget the day that changed our lives forever. It was a Friday and a day off for me. Our mother informed me by phone that my brother had been fired from his job. I pondered the shocking news, trying to make sense of this event. My brother was an intelligent, responsible and capable person. What could have gone wrong? But there had been signs, things that hadn't always made sense and which we naively attributed to stress.

I decided to visit my parents for some probing and later confirmed with my brother that he was mentally unwell. He shared details of improbable things that had happened at the grocery store, in his house, with prac-

tically everyone in his environment. Our conversation ended with a loving hug. I did not think to get my brother to a hospital. I was in shock and also in denial. Mental illness was just not part of our family.

When I talked with his wife, it became apparent that she had been suffering in silence, afraid for herself and in fear of her husband's unpredictable behaviour and erratic disposition. She described that he had been physically, verbally and emotionally abusive based on paranoid ideas. He had isolated her from friends and family during what should have been the happiest time of their lives. He was suspicious, secretive and protective of himself and his family. She asked me to call her parents. It was her father, a physician in Montreal, who directed me to take my brother to a hospital.

My brother came willingly and agreed to be hospitalized. My sister-in-law and I visited my brother's employer, the one who had fired him—again, more evidence that he was in serious trouble. I asked the employer if he would grant my brother sick leave or extend his health benefits given that he was ill. I pointed out that his wife was not working and that they had a newborn son. The answers were unequivocal noes. The employer was not interested in helping in any way.

That first hospitalization lasted about one month. We were told that it was premature for a diagnosis; time would inform us.

That next year was not without its challenges. My brother attempted to return to work. Despite being heavily sedated, he went for interviews and was not successful. Some time that fall, he stopped taking his medication. He was feeling better and did not think he needed it. Life soon became difficult again for his wife. She left him in February 1992, taking their young son with her to Montreal, eventually settling in Ottawa. The house was sold, and my brother moved in with our parents. The family convinced him to attend a program at Homewood in Guelph, which soon set him back on course.

Over the next 10 years, my brother was mostly but not entirely compliant with treatment. He would periodically take liberties. We could tell by his discourse, behaviour and disposition when he cut back his dosage. Paranoia and hostility aimed at family, friends, co-workers and even strangers became a hallmark. The hostility was expressed verbally and sometimes physically. There was evidence of auditory and visual hallucinations, and we would find ourselves accused of things that we had not said, done or witnessed. Getting him back on medication was never an easy task. His illness seemed to progress in severity with each breach of treatment. It was usually through the authority of our father that my brother would reluctantly begin to take treatment again.

Only once did an employer assist with this process by referring him to a psychiatrist for evaluation. Out of that assistance at Women's College Hospital in Toronto, my brother was placed on olanzapine, a drug with fewer and milder side effects than any other drug he had previously taken. Most surprising, the employer welcomed him back

to work. My brother was able to function well enough on medication to be able to work in the computer industry, albeit in a diminished role to the ones he had previously assumed. He also lost jobs along the way when he went off his meds. It was difficult for him to see less-qualified workers being promoted while he was routinely passed over.

In January 2002, we lost our father to leukemia, leaving my brother to live with our mother. Two years later, in February 2004, my brother received notice of layoff from his employer of five years. He was initially poised to look for a new job, hopeful that he would find one closer to home, but things soon changed. My brother had put on quite a bit of weight as a result of taking olanzapine and he had become alarmingly hypertensive. Rather than work with his doctors to figure out a solution, he decided to go off olanzapine. Not only was our father no longer around to exert authority over my brother, but the external pressure of being able to function in a work environment had also been removed by unemployment. There was no one with any level of meaningful authority to intervene in my brother's harmful decision. Our attempts to get him back on track were met with hostile insults and stubborn opposition as the illness tightened its grip.

1340

My brother has never worked since. Our mother, my husband and I tried repeatedly to help him realize that he wasn't functioning properly and that he needed help. I turned to organizations and professionals for guidance on what to do, only to be reminded that the only way to get him to hospital was if he was a danger to himself or others. Verbal and emotional abuse did not meet the required criteria.

By September 2004, my brother's hostility had escalated to the point that our mother feared for her safety. For the first time, we went to the police for assistance. Later that day, they apprehended him and took him to hospital. It was traumatic, especially for our mother, who feared he would be hurt in the process. Fortunately, he went willingly in handcuffs. He was admitted to hospital for approximately two weeks. Conversations with him while he was in hospital informed us as to just how ill he had become. He had totally lost touch with reality. He stubbornly refused treatment and the overseeing doctor had to let him go untreated. He returned home calmer, at least for the time being.

My brother embarked on a friendly relationship with a female patient during this hospitalization, adding a new element to the situation. She became a frequent visitor to our mother's home. Although she seemed nice enough, our mother did not feel comfortable having her around the house with my brother. They disregarded our mother and engaged in inappropriate behaviour in her home. Tensions ran high. Our mother also worried about this young woman: Her son could hurt her.

The next hospitalization was in January 2005, following an incident in which my brother damaged some vehicles outside an ex-girlfriend's complex. The police

were called. My brother was given the option of avoiding charges by going to hospital. We took him to Oakville Trafalgar, where his former psychiatrist now practised. There he denied his behaviours, accused us of making things up and again refused treatment. He was released in short order.

By this time, my brother's hostility towards our mother had become a daily occurrence. He had developed what appeared to be tics and physical hallucinations for which he angrily blamed others. For example, he thought people had their fingers in his ears or that someone was attached to his leg. He sometimes felt people inside him or that he was being stabbed repeatedly. He searched for the culprit and blamed whoever came to mind, including people from his past, people who lived miles away and even people who were dead. He began to focus on our mother as the one responsible for these physical things that were being done to him. He threatened to slap or kill her, and would ask her to leave the house or to give him her money. He even locked her out one day in sub-zero weather. Anything our mother said or did was somehow connected to my brother and his perceptual experiences. Even when she sat quietly, she was accused of saying or doing things according to his aberrant thoughts and perceptions. The hostility turned to everyone and anyone who came to his mind. He visited, telephoned and left phone or written messages for family friends, acquaintances, past bosses and co-workers, companies he dealt with. He was rude and insulting.

It became difficult to hide my brother's illness from others. He quickly lost remaining friends and even our mother's friends stopped coming by the house. We were left to deal with this alone. Our mother slowly succumbed to the stress of the situation. She became depressed and afraid to leave the house because she worried he would get rid of or damage items he thought were somehow interfering with his well-being. She became a prisoner in her own home. She lost her smile and turned into a different person. The effect was profound.

During this time I became a nervous wreck, worrying about our mother's well-being. I called her several times a day at every opportunity I got. I was checking in to see that she was okay and trying to judge whether I needed to take action. I wasn't sure that I could always trust her answers: Our mother protected both her children. My husband and I were over as much as we could so she would not be alone with him. We were on call around the clock. I went to bed fearful of what the night might bring. My cellphone was always on, and I was afraid to venture far from Burlington. I gradually began cutting back my time at work.

In January 2006, the police showed up at our mother's door. My brother had written some disturbing e-mail to a couple of politicians and they had been asked to check things out. With their help, the newly available COAST service came to our mother's home to assess my brother. They found enough evidence to take him to hospital, but we would need to get his physician involved. The police

picked him up three days later following a visit with his doctor that we had arranged. He was admitted to Joseph Brant hospital yet again.

It was at this point that I saw an opportunity to get my brother out of our mother's home if he refused treatment. I explained to our mother that he had to go or she would lose me, her only support. I could no longer deal with how this was affecting our lives. He was ill and we were suffering. I asked for a family meeting, during which I told my brother that he could not return to our mother's home. He was characteristically hostile. I helped him look for an apartment, since the social worker told us this was not her role.

My brother finally applied for CPP disability and moved into a small apartment in Hamilton where the rent left him under \$200 per month for other expenses. He chose to have Internet service but no phone. He cooked gourmet meals and entertained his girlfriend. He purchased gym equipment to furnish his living room, and placed aluminum foil on walls and windows to keep radioactive waves from entering the apartment. He installed additional venting fans and became obsessed with smells, bugs and mould.

Although still worried about him, our mother enjoyed relief from no longer having to contend with threats and insults. She was smiling again, and we were able to take her out to places she enjoyed and to visit with her friends. In August, we were alarmed to discover that my brother had purchased a plane ticket to Italy. A few days before his scheduled departure, an incident occurred at the apartment which led to the involvement of the police and COAST. He was admitted to St. Joseph's hospital in Hamilton.

Our experience at this hospital was very different from our recent experiences at the other hospitals. For the first time in a long time, we were invited to attend a family meeting. Also for the first time, we were given a diagnosis. My brother, we were told, had paranoid schizophrenia, which is what we had suspected all this time. The physician judged him incapable of making decisions about his treatment and asked me to be the substitute decision-maker. I asked that a third party be appointed to support our cause.

My brother contested the decision that he should be treated and appeared before a review board. The board supported the need for treatment. It was looking as though we would finally be able to get him back on medication. My brother, however, appealed a second time and the case was destined for the Ontario Court of Appeal. We were told this could take months. The hospital found itself in a position to have to release my brother because he was no longer a threat to himself or others, and essentially this meant that the case would not go forward. We were also told that even if there were a court order forcing treatment, we would have a hard time finding a community physician who would take my brother on as a patient; it was too much trouble. We were disappointed, because for the first time in a few years there had been some hope that the system would ensure my brother would get the help he needed.

Following discharge, my brother could not go back to his apartment because he was convinced it was infested by mould and germs and that his physical health was being compromised. He stayed at a Burlington hotel for two months before moving into a furnished executive apartment where he seemed to have developed obsessive-compulsive-like behaviours. He disinfected everything that had been in his apartment with boiling water. His knuckles were red and raw. He treated tap water with iodine tablets, took oral medication for ringworm and also had an inhaler. He showered several times a day. I called COAST to come assess him. They cautioned him about his dangerous behaviour, but he was not enough of a danger to himself to be taken to hospital.

While in the executive apartment, my brother had a mild heart attack which required angioplasty and stenting. He was prescribed medication to keep the stent operational. He later discontinued that medication and complained that the stent was actually a communication device used to spy on or to bother him. He suggests to this day that he should have it removed.

My brother was asked to leave the executive apartment. Tenants had complained about him, and he had not paid his rent.

1350

It became clear that he would need a more permanent place to live. I made many phone calls looking for suitable accommodation. Summit Housing in Burlington had vacancies, and they said they would consider him for housing geared to income, even though he was not medicated, which was against protocol. His application was rejected, however. I was told that some of the staff knew him from working out in the field, and they did not want to be involved with him.

Having racked up a huge debt, my brother had no choice but to stay in shelters. Even they became suspicious and started asking for consent to review his medical records. He refused. He approached family friends for money. It became the one thing I kept from our mother.

When our mother came down with the flu in February, my brother offered to stay overnight to look after her. This is how he re-entered the home. My brother's behaviour toward our mother was surprisingly better. He continued to rant and rave, had angry outbursts and was hostile, but it was directed at others outside the home. It was still difficult to listen to day in and day out. Our mother started changing again, and I, in turn, began to withdraw. Our mother was admitted to hospital in December 2007 and died in May of last year.

My brother is now my responsibility. Because of our past experience, I have decided to keep our parents' house so that he can live in a familiar environment that limits his interactions with others. It is added work, responsibility and stress for me and my husband.

In March of this year, we took my brother out on his birthday to see his son, who now attends the University of Waterloo. He was in a hostile, angry mood from the time he got into the car and throughout dinner. At one point, he hit his son on the back of the head in the restaur-

rant for no reason. Later, on the way back from the restaurant, he punched my husband in the face from the backseat of the car with no warning. Fortunately, my husband had just parked the car. The police were called and my brother was taken to Grand River Hospital in Kitchener, where he was admitted. They thought he was very ill and said that if he was their patient, he would not be allowed to leave their facility without treatment. We were once again hopeful that he would get the treatment he needed. The next day, however, my brother was transferred to Joseph Brant in Burlington. I knew this meant that he would walk out yet again, untreated.

The Chair (Mr. Kevin Daniel Flynn): Carla, you've got about a minute left. If you just want to kind of summarize—

Carla: I have how much left?

The Chair (Mr. Kevin Daniel Flynn): About a minute.

Carla: A minute? Really? Okay.

The Chair (Mr. Kevin Daniel Flynn): We're actually over time, but you have a minute.

Carla: Okay. So this latest aggressive incident changed our relationship with him, naturally, and we have been withdrawing a little bit, but we still need to keep an eye on him.

My request for this committee is to look at treatment and non-compliance with treatment. I'm fully aware of the history of people with mental illness and the horrible things that were done to them in the past, but I do feel that the pendulum has swung completely in the opposite direction at this time and we need to find some form of balance so that people can get the help they need.

My brother has something called anosognosia, where he has no insight into his illness. So how can he make decisions about what he needs when he can't see his illness? There are provinces in Canada, like Saskatchewan and British Columbia, which do enforce treatment, and I'm wondering why this isn't possible in Ontario.

Access to better drugs and availability of better drugs with government funding would also be a nice thing to have. Consent requirements, which keep the family out of the picture—my brother refuses to have us involved in his care, so we are completely isolated, not knowing what has happened in hospital.

Also, professional support and assistive services to persons who are ill and not in treatment: It would be nice for my brother to have a caseworker. It would be helpful for my brother to have a caseworker who could act as a consultant to us and who could monitor his situation.

My last request has to do with financial issues. I've given you a summary of them. You are welcome to read them. Essentially, getting my brother to apply for anything is very difficult. He is suspicious of everything. I can't even contribute to an RDSP for him right now, because he won't apply for the disability tax credit. So having some control in that area would be helpful as well.

Also, the financial institutions—my brother has a line of credit and multiple credit cards. I don't understand

why that is the case. Trying to keep him living within his means is very challenging. Thank you very much.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much, Carla, for telling your story and for coming forward.

Carla: You're welcome. Thank you.

HAMILTON ADDICTION AND MENTAL HEALTH COLLABORATIVE

The Chair (Mr. Kevin Daniel Flynn): Our next presentation this afternoon is from the Hamilton Addiction and Mental Health Collaborative. I understand we've got Brother Richard MacPhee and Dr. Lori Regenstreif with us, if you'd like to come forward. There are some clean glasses there with some water. Make yourselves comfortable. I think you were here at the start of the previous presentation, so you know you've got 20 minutes, and the 20 minutes is yours to use as you see fit.

Brother Richard MacPhee: And you're exact.

The Chair (Mr. Kevin Daniel Flynn): Yes, that's right. I'm mean. That's the only thing I'm mean about.

Brother Richard MacPhee: Thank you for allowing us to come here today to present to you.

Just a brief history of the Hamilton Addiction and Mental Health Collaborative: We originally were a subgroup of the previous district health council in which we were an advisory group around the issue of mental health. This group grew after the inception of LHINs and was a mental health group. Then, more recently, within the last year, it has added the addiction community to our table because we see the correlation and the incidences of addiction and mental health really present within the clients that we all serve. We are a number of member agencies, consumers and hospitals systems that are involved in the delivery of mental health and addiction services within the Hamilton community of LHIN 4.

My own background is that I work as the executive director of Good Shepherd Centres and Good Shepherd Non-Profit Homes. In particular, Good Shepherd Non-Profit Homes provides housing and support to almost 500 people who have serious mental health issues and are in need of housing and support. In addition, we provide wellness programs, social entrepreneurship programs in terms of work, and also dealing with the area of crisis intervention through the provision of crisis care beds.

Lori's going to introduce herself.

Dr. Lori Regenstreif: Hi. I'm a family physician with the Shelter Health Network of Hamilton. It's a member of the Hamilton Addiction and Mental Health Collaborative, and it's also quite a new organization in Hamilton primary care. It is a novel program in itself and it has been quite successful.

I'll just give you a little bit of background. I've been a physician for 13 years. My initial years were spent in Vancouver's downtown east side doing HIV primary care and HIV in-patient care. I then went up to Inuvik and spent the next nine years doing rural and remote care across Canada, in the Northwest Territories, Ontario and

the Yukon, and ended up on Manitoulin Island. I was there for three years. So I have a significant amount of experience with primary care in aboriginal community settings and emergency rooms in rural and remote settings where resources are relatively scarce and where mental health services are also extremely scarce, and it falls on whoever the front-line workers are to provide a lot of that. All of that has really informed my work in the downtown inner city of Hamilton with the Shelter Health Network.

As a physician who just likes to do my front-line work and doesn't particularly like to spend a lot of time sitting on committees, I find it difficult to be able to speak broadly for the committee, but I did realize, thinking about it and discussing it with Richard this morning, that I don't have to speak for everyone in Ontario who has a mental illness, for example. What I would really like to speak to is those individuals who have severe mental illnesses that are disabling enough that they are rendered impoverished, without housing or precariously housed, and unwell—unwell physically and mentally. I think we have all heard quite graphically, vividly and poignantly about what that's like on the individual level. For us, as the front-line workers, which is what I enjoy the most, what we see are the successes and the failures of the individual and also of the systems that we're working with to try to connect that individual to meet their needs.

The Hamilton Addiction and Mental Health Collaborative, which we'll just call the collaborative, identified, as a group, primarily areas of concern and issue. Those areas are access to care, so access for people with severe mental illness—I'm not going to talk about mental illness in general, but people with severe mental illness, usually who are rendered impoverished and lacking in housing. Those are the individuals who don't get rostered to family health teams, who don't live in the suburbs, who don't have family doctors, who access emergency and urgent care services disproportionately, who have a disproportionate number of days of in-patient stays because they're homeless or because there's nowhere to discharge them to. As well, moving them from one service program to another can be very difficult because those people don't function that well. These individuals just aren't able to get themselves from A to B on their own; they can't necessarily function independently when they're unwell. So access and transition are issues that we've identified.

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Connecting them with primary care is a huge problem that—again, we work with the family health team of Hamilton, and the family health team of Hamilton has had a key role in providing mental health programming that's connecting elsewhere in the system. They're part of our collaborative. What the Shelter Health Network has is somewhat novel; we could call it a model in and of itself for provision of primary care to individuals with mental illness in Hamilton. I just very quickly will summarize it because it's only a couple of years old. It's a group of physicians, nurse practitioners, nurses, social

workers, front-line workers, and shelter staff and shelter administrators in Hamilton. We started out as a table; we all sat at a table about three years ago and envisioned a way of bringing primary care into the sites where people are rendered homeless, so the shelters in Hamilton. We've had a wonderful co-operative series of meetings over the years, and we still have them, with the shelters.

I was telling Brother Richard that I like to describe our model as a "stone soup" model. The shelters give us a pot, the ministry gave us some water, and the water was funding just for the physicians, which is a special kind of funding that I think belongs in a setting like this where doctors are paid by the hour. This is really important. For people with mental illness, you cannot function in the fee-for-service system. They're not accepted by fee-for-service, and they don't work in rostered systems either because you can't roster someone who's drifting. So we've been funded as an APP, which means we're just paid sessionally, and we roughly decided how many family physicians we were going to need and what kind of services we needed. We knew we'd need psychiatry and we suspected we'd need some internal medicine support. As it turns out now, we also need chronic pain management support with anaesthetists. We're not getting that quite yet, but we're hoping that will come through.

We get called "oh, the best doctor ever," because we have a whole hour with somebody, but they've needed these hours from us and they get them. We become the point of contact for them. So if you're homeless or you have an addiction or a mental illness that's brought you to a shelter or it's brought you—we're also detox addiction services. Wayside House and Claremont House are all different forms of treatment programs and they're all points of contact for people with addictions and mental illnesses or at risk of one or the other, because if you have one you're at risk for the other. At that point, we bring them into the setting of primary care. We then coordinate with the family health teams. Once people have been stabilized, they're usually in our care for anywhere from six months to three years. We try to move them into a new program, a bridging program with bridging nurses and the family health team, which has agreed to take our patients as they become easier to care for.

Again, it's really hard for me to speak for the whole group. I'm speaking for what I do and what we do, but what we've managed to do is to address some of the issues that we've put into this brief in terms of areas that aren't necessarily being met. This is one area I think that has been successful. Richard's going to speak—

Brother Richard MacPhee: The Shelter Health Network is one of the areas in which our collaborative has come together. We've also come together around the formation of the HOMES program, which is housing with on-site, mobile, and engagement services. We've come together in terms of some of our addiction responses. We've also come together in terms of, for example, the COAST program that was cited earlier. It's a model that started in Hamilton and came from this

network, which actually at that time was a network. It now is a collaborative.

We also recognize that as we've been working with people who have serious and persistent mental illness, or at least are in the beginning stages of that, we see a lot of young people in our community who are in need of services. They're being seen in the Shelter Health Network, they're seen by mental health clinicians who are working on the streets. We are also seeing them in the Cleghorn program, which was established for early intervention for young people with first-break psychosis and things like that.

I think the other part of it is that we really, as a community, have embraced and struggled to embrace the concept of recovery and how we as agencies centre around a recovery model which involves peer support, which involves consumers within the delivery of services, and also the whole issue of how we change some of the cultures within our organizations and hospitals that make us more recovery-oriented.

Another challenge that we've all been dealing with is the whole issue of concurrent disorders and the issue of mental health and addictions, and one of the ways that we as a community have responded to that has been the whole issue of cross-pollination. We've really spent a lot of time in terms of agencies hiring addictions specialists, addictions agencies having resources to mental health practitioners, addictions agencies having access to, say, the Shelter Health Network or other physicians within that. So there's some movement back and forth in which we've been able to help the clients we're serving.

One of the things, for sure, in what we worked on was the whole issue of emergency usage. Many of the folks we see are often seen as frequent flyers within the emergency health care system because they don't have access to primary care or they don't have access to mental health services. I think we have a really good crisis outreach team, we have a good crisis care centre in Hamilton, but I think some of the challenges are what happens to our clients when they come to the door of an emergency room, either with a practitioner or by themselves, and how long they sit and how often they have to become medically certified before they can even begin to see someone within the mental health system. We know that within our family health teams there has been a way to circumvent some of that stuff, and I really think there's a challenge for us to figure out how we can divert some of these folks away from emergency rooms and make sure they don't use some of those valuable services and can in fact have service in a different way that is less intrusive and less expensive.

The other issues are the social determinants of health. One of the things that we really see is that if you don't give people a place to call home, you can't even begin treatment. We hear time and time again, "What do people want?" They want a home, they want a job and they want a friend. To have a friend, you have to have a place to meet with them, a place to welcome them. One of the things that we've also seen is that as people get stable in

their own housing, they also want meaningful activities and work, and we've seen time and time again their need for that. Particularly, we're also seeing that as people have been in programs for a long period of time, they age in those programs, so they have some of the unique issues of having a mental health issue and aging, and there are barriers to services that some of those folks are experiencing through either CCAC services or other services that may in fact allow them to live in their communities without some of the services that other people are entitled to.

Trauma is a big issue that we're seeing within our community. Within the province of Ontario, Hamilton is the second-largest welcoming point for newcomers. We're seeing a number of people who are coming from war-torn countries who are victims of trauma, women and children who are victims of domestic violence, and abuse in young people.

I think the other part of it is that we have really worked hard in this community to have consumer involvement within our programs. We've had consumers involved in peer support roles as clinicians, and that has been a real blessing for all of our programs in terms of how we've changed some of the cultures and some of the recovery models within our various programs and how we adapt to recovery.

I think I'm going to leave it there because I really would like to leave the floor open for questions instead of just talking at you.

The Chair (Mr. Kevin Daniel Flynn): That's great, Brother. Thank you. It's 2:09, and you've got until 2:14, so we've got time for probably a question from each party. Mike Colle?

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Mr. Mike Colle: I'm just very impressed with your commitment and this very innovative approach. Have you had any discussions with the Ontario Ministry of Health, which has an initiative under way right now to reduce the impact on emergency rooms and to find new strategies? Have you talked to the Ministry of Health?

Brother Richard MacPhee: To the local LHIN, yes. The LHIN has been responsive in terms of some of the stuff we've been doing and how we've been diverting people from emergency rooms. The Medical director, Dr. Myles Sergeant, and myself have been in contact with the local LHIN around what we're doing. We, right now, have a lot of the support from the physicians, but a lot of the other supports are coming from the agencies. They're getting piecemeal pieces of money, but in reality we are hoping that at some point in the future, the LHIN will see this as an emergency room diversion program and an ALC diversion program.

Mr. Mike Colle: Just as a follow-up, could you, along with the submission to the committee, and I'm sure you can give a copy to all the members here—

Brother Richard MacPhee: We have provided copies to the clerk.

Mr. Mike Colle: But just a one- or two-pager for a layperson on how this program works as a diversion. I

will certainly give it personally to the Minister of Health and ensure there's a follow-up on it, besides the presentation you're making on mental health here. Because we've got serious problems in Toronto on this emergency backlog, because people who are in high need are coming there right now.

Dr. Lori Regenstreif: I just wanted to comment on something we didn't actually discuss that much, and that was the support of self-evaluation for the programs. For example, for us, we have to—and I didn't really finish my stone soup metaphor. We've actually been trying to piece together from—because an APP contract to pay physicians is only that. We were actually disappointed that that was all the ministry was willing to do at that point. So we have been piecing together with—

Brother Richard MacPhee: We were disappointed but grateful.

Dr. Lori Regenstreif: The shelters have become our transfer agencies for different types of funding. What we've needed—and we've been getting bits and pieces of—is funding to do self-evaluation, where we can show some outcome measures. That's a challenge, and none of us has the time. We're working on how we hire or contract someone to do that research so that we can bring the numbers back, because that's what they want to hear. They want to hear the numbers. They want to know that there's impact.

The Chair (Mr. Kevin Daniel Flynn): Question, Sylvia?

Ms. Sylvia Jones: In your brief, on page 2, you talk about the transition of bridging the youth into the adult services. Can you talk about what you have been doing, either successfully or where the roadblocks are with that?

Brother Richard MacPhee: First of all, I think there are some challenges between the Ministry of Children and Youth Services and the Ministry of Health, particularly in terms of that population, and also within the delivery level, in that young people, particularly those between the ages of 16 and 18, fall into two categories, one in the adult system and one in the children's system. In Hamilton just recently, we've opened some new mental health beds that have been in the offing for a long period of time, and we have yet to see what that response is. One of the challenges will be that not only are they mental health beds but they're tertiary care beds, so they're going to look after needs within the whole LHIN. We've had some preliminary discussions of where those kids go afterwards, because some of them will be able to go home but some will not be able to.

We have an agency in Hamilton which is called Contact, where all children go for assessment and then a recommendation in terms of a plan of treatment. There has been funding through the Ministry of Children and Youth Services for mental health clinicians, and our agency runs a youth shelter. We have clinicians on the streets who are working with kids and trying to access service, but really, some of the challenges that we're experiencing are, when we identify that kid, how do we get access to service and make sure that we connect with

a psychiatrist? We've been lucky in terms of having a psychiatrist within the shelter coming in and visiting, but it's all about relationships. It's not necessarily always about resources. It's about, you know somebody, they do you a favour, we do you a favour and we get something done.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Brother. Thank you for coming today; unfortunately that's all the time we have, but that was a great presentation. Thanks for all you do.

Brother Richard MacPhee: Thank you very much.

M^{me} France Gélinas: Can I ask a yes or no question?

The Chair (Mr. Kevin Daniel Flynn): I don't know. This is a doctor and a brother; are you likely to get a yes or no?

Brother Richard MacPhee: You might get a blessing.

The Chair (Mr. Kevin Daniel Flynn): Okay, let's try and see what happens.

M^{me} France Gélinas: Just curious to see if any of your agencies offer services in French.

Dr. Lori Regenstreif: Within our collaborative—

The Chair (Mr. Kevin Daniel Flynn): That could be a "oui" or "non" question.

Brother Richard MacPhee: We have nurse practitioners that speak French. Yes, we do have that. I'm just trying to remember.

Dr. Lori Regenstreif: Some of us speak French and have had to run a clinic in French. We've had to do that before. There's also the Francophone Community Health Centre, but we haven't aligned with them officially.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much.

CANADIAN ASSOCIATION FOR PASTORAL PRACTICE AND EDUCATION

The Chair (Mr. Kevin Daniel Flynn): Our next presenter today is Robert Bond from the Canadian Association for Pastoral Practice and Education. If you'd like to come forward, Robert. Make yourself at home there. Get a clean glass.

You've got 20 minutes. You can use that in any way you see fit. If you can leave some time at the end, that would be great, but it's not necessary.

Rev. Robert Bond: I'll try to.

The Chair (Mr. Kevin Daniel Flynn): The mikes work better if you're about a foot away from them. It's all yours.

Rev. Robert Bond: Mr. Chair and members of the select committee, as you have heard, I'm Bob Bond. I am the coordinator of spiritual and religious care at the Welland site of the Niagara Health System. Within the Canadian Association for Pastoral Practice and Education, which I'll call CAPPE throughout this time, I'm certified as a specialist in pastoral counselling and I am co-chair of an Ontario working group on college formation. Thank you again for this opportunity to address your committee.

I have three goals to meet before you. One is to inform you about the work and role of clinically trained chaplains and pastoral counsellors as mental health professionals in Ontario. A second goal is for you to hear from our group affirmation and hope concerning the College of Psychotherapists and Registered Mental Health Therapists. The third is to explore mental health and addiction caregiving needs in Ontario, and how this college's breadth in general and CAPPE's leadership in the specialization of spiritual care therapy in particular can help address the needs.

First, something about CAPPE: Most people, be they patients or practitioners of some sort, bring with them a caricature of the chaplain or the pastoral person that is, at best, something like Father Mulcahy from that wonderful television series *M*A*S*H**, and at worst, something like a fundamentalist preacher or televangelist. Even at the better end of this continuum, the Father Mulcahy end, he was a kind and gentle and generous and humble soul, but he was initially quite unaware of his own depths, pretty much stuck in dogma and ritual, and clearly untrained in what he had to face there.

CAPPE, alongside five fraternal American professional associations and several others globally, has for over 50 years in Canada done the clinical training and certifying of specialists and teaching supervisors and their ongoing peer-review processes and all the standards and professional ethics processes, including complaints with the judicial committee appeal process, which together turn a nice and religiously attuned person like Father Mulcahy into a grounded and fully functioning and fully backed spiritual care therapist. Father Mulcahy, by the way, would have done tremendously well in CAPPE because of his openness to hard reality and his honesty with himself and others.

There are 651 members of CAPPE nationally and 347 in the province of Ontario. Of these, 103 are certified as specialists in pastoral care—working in hospitals, prisons, the military, long-term-care facilities, university campuses, drug and alcohol treatment centres, palliative care teams, community health centres, family health teams and a few in churches or local communities of faith. Then there are 28 more alongside me who are specialists in pastoral counselling, working in community counselling centres, employee assistance programs, private practice or any of the previously mentioned institutional settings.

Some folk may bristle at the naming of chaplains and pastoral counsellors as mental health and addiction care providers. At our first meeting with Joyce Rowlands, registrar of the College of Psychotherapists and Registered Mental Health Therapists, I told her about a case from that morning. A patient—and these details are told so as to mask the patient's identity—had come into our emergency room with an infected foot. He was a professional athlete. He lived with a woman with a severe mental health diagnosis whose own needs and demands had, over the years, pushed our current patient to a place where much of his energy was now spent reacting to and

managing her state of being. His care for himself, and in particular his care for his diabetes, had fallen by the wayside, and so came about this foot problem, which straightforward got diagnosed as gangrene.

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Then came necessary, hard decision-making about amputation. I was called in and was met with his declaration, "My life is over anyway. I'll never compete again—the doctor told me so. I have nothing to live for. Why put myself through the surgery? I'll just let things take their course." He had decided no to the surgery with his surgeon and nurse. It was the nurse who referred me to the patient.

The patient and spiritual care provider talked for an hour or more, with the spiritual care provider carefully reflecting back what the patient described and wrestled with. In this process he came to see that his words, "My life is over," were for him an accurate description ever since choices upon choices he made ages ago, whereupon he stopped paying attention to, let alone nurturing and developing, his own life. He had become, in fact, a casualty to his partner's mental disease, that ongoing downward spiral, and he saw clearly that current decision-making about surgery was, in some ways, less demanding than other decisions to be made if he was to choose for life now. He knew, for instance, he could coach rather than be the athlete; he had other talents and passions that could continue unaffected by the loss of his foot or leg. But more fundamentally, he started to imagine his life readjusted so that care and attention to self and nurture of self were put back in place.

Joyce Rowlands heard the story and responded as to how the intervention so very fully lives out the controlled act of psychotherapy. This from a hospital chaplain's everyday work, which is soul care, and therefore, to the etymology of the word "psyche," this is psychotherapy, or mental health care. Now, I should also make explicit, beyond this example, that chaplains and pastoral counsellors directly address mental health illnesses and addictions in the majority of the settings where we work.

CAPPE's 347 Ontario members attend to over 100,000 citizens of Ontario in a year, and this is me being pretty conservative with an estimate. Our clients across the institutions and private practice settings previously portrayed are folks in some nature of crisis, and we are there to foster consciousness—or, if you prefer, clarity—and connectedness, which some might describe as being grounded and resourced, as these people make their way into their crisis, through it and beyond.

Within Ontario, as a member of both the Ontario Coalition of Mental Health Professionals and the Alliance of Psychotherapy Training Institutions, CAPPE is glad and grateful for the provincial government's work in creating the college of psychotherapy and in conducting the current comprehensive, critical and creative review of how the mental health of Ontario's population can be resourced and improved.

Concerning the college, CAPPE Ontario would urge the government to be expeditious in moving to bring the

College of Psychotherapists and Registered Mental Health Therapists to life. This next requires the actual naming of members of the transitional council, to which naming we look forward in hopes of broad representation for the multitude of currently unregulated practitioners within the province. Here, CAPPE Ontario thinks of the 5,300 members within our Ontario Coalition of Mental Health Professionals.

Also, CAPPE Ontario recognizes spiritual and religious care practitioners outside our organization, and standards, certification and training, but equally addressed by HPRAC, whose 2006 new directions document noted, "Commentators strongly supported the proposition that faith-based practitioners who provide psychotherapy during the course of spiritual or religious care should meet the same qualifications and standards as other practitioners of psychotherapy. This is a matter that should be reviewed further."

Concerning the review and progress here, and in line with your committee's broad mandate, CAPPE Ontario knows that improving our society's mental health is about more than simply expanding access to the Ministry of Health's currently funded services. Furthermore, in line with the Ministry of Health, CAPPE Ontario knows that not all people want or need to receive care within a narrowly defined medical model.

As a practitioner in Welland, for instance, I can point to a broad band of citizens. We've come to call them the worried or wounded, but walking, poor, who are caught up cycling through systems that seldom, if ever, address their mental health needs. If these people do spiral further into severe mental health diagnosis, they then can access treatment via psychiatrist, an outpatient mental health clinic and a public health nurse. But just as they are hurt by trauma, abuse, complicated losses, addictions or the basic and stark deprivations of poverty, there is no mental health resource they can access. In our society, people with money can purchase fee-for-service psychotherapy of many sorts, people with a strong employee and family assistance program from their workplace can get counselling there—a few sessions, anyway—but we watch the worried or wounded, but walking, poor cycle through doctors' offices, emergency rooms, police stations, courts and prisons without any salve for their wounds. These folk need primary health care that includes, and indeed provides without barrier, psychotherapy.

In some jurisdictions, community health centres and family health teams are recognizing and building upon this fact. I know from the earlier presentation, that there was a reference to the Hamilton family health team; they have, for instance, a chaplain on that staff. In some alternative systems of care, such as the work of wise elders in our native communities and the work of rabbis, imams, priests, ministers and others who do pursue training and credentials for use in their local faith communities, the needful care is provided and the results are pleasant to behold. To open up more channels of the same is the challenge that CAPPE Ontario believes or hopes you committee members are here to address.

One barrier might get removed in the follow-through to the bringing to life of the College of Psychotherapists and Registered Mental Health Therapists. If this college's pool of then-registered resources can become funded and applied more fully and creatively, then there's a lot of resources, and the worried or wounded, but walking, poor and everyone else in the province could get far more ready access to what they really need close to home in their local community's primary health care system, be it a health care centre or a family health team or whatever—and then at the next level, not only at the local hospital but through their CCAC and at the end of life within their palliative care team.

In support of which suggestion, without the addictions counsellor, the art therapist, the child therapist, the marriage and family therapist, the music therapist, the nurse psychotherapist, the occupational therapist, the psychotherapist, the spiritual care therapist, the physician-psychotherapist, the psychologist-psychotherapist, the recreation therapy person and the social worker bearing psychotherapy credentials—without these, watch as the general practitioner tries to address the patient with a generalized anxiety disorder, borderline personality disorder or the patient dually diagnosed, to name but three. Watch that GP try to make referrals within and across the medical model and see just how far the case progresses: We are back to cycling around without resolution. Then make interdisciplinary caregiving real and accessible, put the addictions counsellors—that whole long list of psychotherapists, and I'll underscore that spiritual care is among them—to work within primary health care, and it all goes very differently.

Similarly, if realization of the College of Psychotherapists and Registered Mental Health Therapists opens up routes of care via third party payment, again we end up with a truly interdisciplinary approach in order to address the mental health needs of accident victims and victims of crime.

Answering a likely argument that this means increased costs, well, if such channels are opened, then there's the evidence-based truth that when people's actual needs are met, they stop cycling around the systems—the wrong systems that otherwise and somehow have to address them encounter after encounter, eventually by blaming and marginalizing them encounter after encounter.

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Similarly, there are people within our province's psychiatric systems, perhaps by and large outside major centres, being repeatedly stabilized and discharged with a focus on pharmacy and little reliance on addressing the meanings—the meanings of the condition and the meanings of its origin and the meanings of life lived in its grip. In other words, with little reliance on the possible psychotherapeutic interventions. There too come evidence-based discoveries that as actual deep needs are met with people with severe and profound psychiatric diagnoses, the cycling slows and, better yet, the quality of life improves.

So public access to fully interdisciplinary care right across the many domains of psychotherapy is a creative,

needful, human-resource-effective and cost-effective thing for Ontario to do.

To summarize and to emphasize by way of refrain, CAPPE is a self-regulating professional body of chaplains and pastoral counsellors pleased to await inclusion in the College of Psychotherapists and Registered Mental Health Therapists. The specialization we seek to populate there is spiritual care. As spiritual care therapists, we put ourselves forward in our current institutional and private practices and from there into far more broadly possible primary health care settings which systemic change can make possible. We put ourselves forward as a leading discipline among the providers of the healing of illness, which, alongside medicine's curing of disease, will very much help address the province's mental health and addictions needs.

I again thank you for your attention to CAPPE Ontario within these current hearings, and I'm open to entertain conversation and questions.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Bob. Thanks for your presentation. You've left about four minutes. If we have really short questions and short answers, we can probably get one from each party. Let's start with Sylvia.

Ms. Sylvia Jones: You mentioned that you have 347 members across Ontario.

Rev. Robert Bond: Yes.

Ms. Sylvia Jones: I am familiar with the hospital-based chaplains in my community. Would every hospital have chaplains who are affiliated with CAPPE?

Rev. Robert Bond: No, not every hospital does, because currently it's not a requirement. It's something that we certainly urge and try to promote, but there is freedom to hire whoever they believe will fit the bill in their accreditation process. I imagine possibly a third of the folks hired are not connected with CAPPE.

Ms. Sylvia Jones: Okay. Thank you.

The Chair (Mr. Kevin Daniel Flynn): France?

M^{me} France Gélinas: You'll have to forgive my ignorance, but what you're saying is that under the College of Psychotherapists a pastoral care practitioner cannot register?

Rev. Robert Bond: No. It's a good question, though. The college has yet to register anyone. It's still in formation, having had the legislation pass a couple of years ago. We're waiting for the transitional council to do its work, which will take another couple of years, and somewhere in there the registration process will begin for all of us who are currently unregistered, not only spiritual care but art therapists, music therapists, marriage and family therapists—the whole raft. So we're all just standing, waiting to enter.

M^{me} France Gélinas: In the transitional college board, the people who are there, are some of your members being represented?

Rev. Robert Bond: We're not sure yet because it hasn't been named.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Bob.

M^{me} France Gélinas: So we're at that point.

The Chair (Mr. Kevin Daniel Flynn): We'll move on. Helena?

Ms. Helena Jaczek: As you know, we've heard some very moving stories from families of young people particularly who have been diagnosed as schizophrenic. Obviously acknowledging what you've said, that a full interdisciplinary team is very valuable, I'm just wondering if your members have been involved in assisting the individual with mental illness, perhaps at the request of a family member, to in fact seek pharmaceutical treatment. Have you been involved in that kind of assistance to families?

Rev. Robert Bond: Are you thinking within institutions or out on the streets? I'm just wondering what the setting of your question is.

Ms. Helena Jaczek: Either.

Rev. Robert Bond: Okay. Certainly within institutions we're fully part of the interdisciplinary team and would urge full treatment of people's conditions. So if they're being resistant or non-compliant or hesitant around the use of medications which are obviously best practice, our role would be to try to work and understand the blocks and the perceptions and to certainly make good argument and use of the full spectrum of possible responses, including the pharmacological.

The urging I'm doing here is, yes, use the medication, but it's also important to address the meanings, the situation, the roots, the experience of living within this condition, and to do it with eyes wide open. That's what spiritual care providers are grounded in: exploring and helping people to address the meanings.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today, Bob. It's appreciated.

Rev. Robert Bond: Thank you.

MARLENE WESTFALL

The Chair (Mr. Kevin Daniel Flynn): Our next presenters for this afternoon are Marlene Westfall and Manon Marquis. I'm not sure—I'm sorry?

Ms. Manon Marquis: I'm just here to support her.

The Chair (Mr. Kevin Daniel Flynn): Oh, good. We all need support. You should try election time.

Ms. Marlene Westfall: No, thank you. This is hard enough.

The Chair (Mr. Kevin Daniel Flynn): Anyway, you probably weren't here when I introduced the last delegation. You've got 20 minutes. You can use that any way you see fit. If you want to leave a little bit of time at the end for any questions, perhaps that would be a good idea.

You'll find that the mikes work better if you're about a foot away from them. There's some water there if you want; there's a clean glass over there if you need a glass of water or something like that before you start.

Interjection.

The Chair (Mr. Kevin Daniel Flynn): That's right; it's a certain amount of centimetres. They're saying that I'm old-fashioned because I'm still using feet and inches.

Ms. Marlene Westfall: That's okay; I speak both languages.

The Chair (Mr. Kevin Daniel Flynn): Anyway, the floor is all yours. If you'd introduce yourself and your guest as well for Hansard, that would be great.

Ms. Marlene Westfall: My name is Marlene Westfall.

Ms. Marlene Marquis: And I'm Marlene Marquis.

Ms. Marlene Westfall: Before I commence, I'd like to thank the select committee for allowing me the opportunity to bring my concerns to this forum. It's still with great difficulty that I write this submission because of the trauma experienced at the hands of individuals in positions of trust in what we call the mental health care system. I would prefer to coin it the mental health abuse system, because there was nothing caring about my experiences in Hamilton by those within the circle of care and those individuals who have been fraudulently holding out as social workers.

What are supposed to be protected legal rights saw my confidentiality violated in such a perverse manner that there's no doubt it could be interpreted as deliberately cruel. Individuals who ought to have known what constitutes good medical practice and professional conduct appeared to involve themselves in a strange form of medicine.

The charter, whose ambit has been decided in the courts to include hospitals and government agents with legislated obligations, appears to have forgotten that law, the Canadian Constitution Act, 1982, which guarantees every individual the right to safety and the equal benefit and protection of all laws in this country.

Lack of confidentiality and acceptance of clear consent between St. Joseph's hospital and a number of women's shelters was non-existent. Fraud, slander, contempt for legal rights and an "I know what's better for you than you do" attitude replaced the good medicine that is practised in other parts of Ontario.

Access and disclosing personal health information without consent is so serious, there is an offence clause built into the act.

Stated law through Supreme Court decision indicates that hidden and secret files, including written notes, if used to make an assessment or diagnosis, are within a patient's right to access.

Protecting patient information is a human right and also has been decided in the courts as a protected constitutional right, as misuse through fraud can harm a patient, especially those trying to recover or reduce their symptoms within a mental health context.

Stated human rights law and judgments recognize the vulnerability of this enumerated group. This province's human rights commission has provided commentary, in an accepted format as to include it in evidence, that denying an individual under enumerated grounds from obtaining services or withholding services as a result of policy, such as medical care or accommodation, based on that person's perceived disabilities amounts to discrimination.

Entering into a health care and women's shelter system that already holds perceptions about patients with mental illness is compounded by information generated and passed without the benefit of individuals within the circle of care being registered with the college of social workers, where, according to the college's code of ethics and standards of practice, they would have to ensure that they have an understanding that they are in positions of power and have a responsibility to ensure that their clients are protected from the abuse of such power, and any recommendations or opinions they provide are substantiated by evidence and supported by a credible body of professional knowledge. Included in the information is collateral information, and it must be documented.

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In August 2004, I was removed from a woman's shelter, referred to as shelter number 2, because it was assumed I had a mental illness of some severe extent. I was labelled with a dot blackballing me from future accommodation and from good medical care, as information from Hamilton's women's shelters was passed on to the hospital without my knowledge or consent. This is where it begins.

I went to hospital on September 7, 2004, on a voluntary basis to seek medical help for extreme anxiety and suicidal ideation. I asked for an assessment. I was very frightened as I had never experienced anything so intense and out of control in my life. On this visit, the admitting physician confirmed with me that I would be asked to sign a hospital consent form. This was never done. I was refused treatment by the assessing physician, who was still in residency. None of her peers were assessing with her. I was refused medication to calm me down. Staff at the shelter could have managed these meds in a locked cabinet in the staff office.

The notes taken by nursing staff were judgmental and did not note that the physician refused to provide support to alleviate elevated anxiety caused by decisions of the shelter staff. The shelter staff had me sign an illegal consent form 14 that was repealed in 1995. The staff signed only her first name on this legal document.

The shelter staff collected personal health information from the hospital. The manager confirmed it by telling me, "I know what's wrong with you," but did not share with me what the hospital told her.

The shelter staff were holding out as social workers. None were registered as social workers or social service workers confirmed by the college of social work. A woman associated with Status of Women Canada confirmed that the staff were qualified to provide one-on-one counselling and take notes, which they did. The staff later admitted that most were trained in criminology, not social work.

The shelter was supposed to provide a personal needs allowance, or PNR, on a weekly basis, but the staff didn't know what it was. I signed a consent form with shelter number 2 so they could contact shelter number 3 regarding PNR only. The Ministry of Community and Social Services confirmed shelter number 3 was re-

ceiving money from the government to pay for PNR, but I never got it. Since shelter number 3 was getting money for each resident that resided there, I was barred from applying for welfare so I could get first and last month's rent for a room or apartment so I could get out of the shelter system.

I was looking for another place to stay. When I got a phone call from a friend who was trying to help me out, staff did not let me know the call came in, despite me being in the house and the constant requests to other residents to take their phone calls. I felt I was being centred out.

I was refused by staff to allow me to room with residents I was comfortable with. My roommate moved out, but I was forced to stay with an individual whom I knew from shelter number 2. I knew it would be difficult to get along with her and such would increase my anxiety. It was almost as if they knew and deliberately put us together at an inopportune time.

I requested help from shelter staff to get belongings that were with the woman I had been staying with but who refused to give them back. The staff kept saying their van was being used by another site. I felt like I was in jail and there were no avenues to escape the shelter system in Hamilton. It was like I was being forced to stay against my will. This spurred another anxiety attack.

I made a second visit to hospital as treatment was denied on the first visit but the symptoms were getting worse. I had the same physician I had on the first visit. I confronted her about why she told me she would give me a doctor's note and then left without providing one. This was not documented in the medical record. I told her I had every right to request accommodation at the shelter to alleviate heightened anxiety aggravated by deliberate actions of the staff and it was my right to state it under section 8 of the Ontario Human Rights Code. She documented that as a medical symptom, not a legal right.

In the morning a nurse came in to finish the medical assessment instead of a physician or psychiatrist. A number of hours later, I was refused medical treatment again with the bizarre excuse that my "anxiety was too high." No medication was provided to reduce the anxiety. I was told to go to Catholic Family Services for counselling, or I had the option to apply to their outpatient services. The hospital staff still told me that I had a room at the shelter. Whatever it was that the hospital staff were trying to do, none of it made sense, nor did it appear they were practising medicine. It's almost as if they were working for corrections and couldn't differentiate their role to the greater public outside of this system.

When I returned to the shelter, I was refused all my personal belongings, including my eyeglasses as well as my car. Without just cause, I was forced to look for my glasses on the porch of the shelter, a rather humiliating experience but pleasing to the staff. I recall the staff member had pleasure telling me to go to another shelter with a very bad reputation. The shelter was refusing to give me my car, without just cause, even if there was such a thing. They were trying to keep me from using my

car to sleep in as they unlawfully impounded it at their other, government-funded facility. I had to go to the Hamilton police to get their help in getting my car back. I managed to stay at a friend's house for one night and was finally able to apply for emergency welfare.

The next night I slept in my car at a campground because I had no place to stay and I had a mandatory welfare meeting the next day. This was the worst night of my first month in Hamilton. I struggled all night not to take the pills I had in my car. I forced myself to listen to music and not go to the hospital, as I was afraid of missing my appointment. I did make it to the appointment and was signed up. They even gave me a Tim Hortons card. There appeared to be some hope.

Since I was made homeless a second time by a women's shelter and was refused medical treatment twice, I drove to Windsor to get medical treatment and stay at my parents' only because they were away on vacation. When I arrived in Windsor, I checked the voice-mail messages to find that the RN doing the assessment had contacted my parents' home without my consent. I contacted shelter number 3 to revoke my consent. I was told by the manager I could not. I was also told that all information about their residents is shared with all their facilities, all without consent. I started having anxiety attacks again and contacted the women's shelter in Windsor, where I was given support. They were honest in telling me that they did not have the qualifications to help me, despite all staff there being either registered social workers or studying social work at university. They knew their limits, and I appreciated that. I was afraid to drive, so they provided me a taxi chit to the hospital.

At Hôtel-Dieu in Windsor, they triage you, then you see a qualified registered social worker. The social worker decides whether or not you should see a psychiatric nurse for further triage and then a psychiatrist. This time I was referred to a psychiatric nurse. I was treated with dignity and respect. The nurse said to me, "What you've been through would make anybody suicidal." I then saw a psychiatric resident who was very kind and non-judgmental, and then a psychiatrist. He asked me if I was depressed and of course I responded, "Yes." He prescribed me medication to alleviate my anxiety and to help me sleep. I was finally able to sleep a full night and start to feel more in control.

I returned to Hamilton and rented a room and set up an appointment with outpatient psychiatry. Two days after I moved into my new room, my car was stolen.

At St. Joe's they continued to give me a hard time. I was told that I would be able to access the program despite where I lived. When I met the first clinician, she called me a liar without checking that I was given the okay to get their services out of the catchment. She didn't like that I was getting services out of the catchment. The same nurse clinician continued to be verbally abusive, calling me a bitch and telling me that I had been abusing the system in Windsor without benefit of medical proof from the medical records. She abused my privacy after we had discussed how a female roommate in my new

residence was being threatened by one of the males living there. I was scared. Instead of being supportive, she picked up the phone and gave a police officer fabricated information about me in front of me. She knew I already had issues with the hospital breaching my privacy. When I was asked to take medical tests for diabetes, she told me not to bother with the fasting. She said that she never does. This would have made the outcome very different.

On one visit, I was feeling faint. I had asked a person working at the information booth to help me walk to the outpatient building. She said to let the staff at outpatient know that I was not feeling well. I did, but they did not pass it along to the clinician. After the appointment, I was still feeling faint and sat down in the waiting room, drinking water. When reading the notes of this event months later, the clinician had documented that I was sitting in the waiting room for no reason. I had told her that I was feeling faint, but she didn't document it. The reason for this was that I hadn't been eating from the depression and lost 30 pounds. Later tests showed I was anaemic and had inner ear damage, but it appeared this clinician wanted to document some sort of bizarre behaviour instead of a real medical reason for why I was resting.

I requested to go to another clinician and wrote out my concerns in detail. The next clinician I had was a registered social worker. I was there for a month before I got a call from a researcher at St. Michael's Hospital in Toronto. It turns out that the clinician had forwarded my name for research on a mental illness I hadn't been diagnosed with and she did it without my consent. She knew this was a serious issue for me that shouldn't be manipulated, but forwarded my name anyway because the hospital seems to have total disregard for the legal rights of their patients in this branch of medicine. It turned out that I didn't have symptoms of the mental illness to qualify for this research study.

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I made an appointment with the research ethics chair, and he told me what they did was illegal. I was given an apology letter and decided that if I didn't leave this hospital with all its abuses, I would eventually become seriously mentally ill and be institutionalized, so I left the program.

In November 2004, I asked my mother to attend with me to shelter number 3 so I could obtain and access the notes the staff had been taking in our counselling sessions and to see what information they had passed on and obtained from the hospital. I was refused by the same manager to see my file, so she read it to me. She confirmed that the hospital had contacted them on the second visit.

I applied to get my medical records from St. Joe's. I was asked what I was looking for, and told the records manager that I wanted to see a consent form giving hospital staff the right to contact my family and the shelter. She provided me a copy of the illegal form 14 that was given to them by shelter number 3, not one from the hospital. About a week later, I learned that my brother

had been contacted by the assessing nurse, and she had been asking him questions like, "Does she have a son?" and "Did she go to university?" She did this without my consent.

I again applied, but this time I wanted to go through the file. I went through the full file with the copies I had been given earlier with the ones that were already there. I decided to look in another area of the file, and it was here that the records manager had placed medical records that should have been with the rest of the medical file and not in the communications portion. In these records, it was recorded that the resident psychiatrist and the assessing RN who had contacted my mother and brother had written that they were going to contact them and the shelter for collateral information.

According to Supreme Court decision *McInerney v. MacDonald*, I have the right to access all of my medical record, including any notes on collateral information or history obtained from anyone that is used in making a medical assessment. These notes, or any information taken obtaining collateral information from my family members and shelter staff, were not in the file, but they should have been. I made at least five requests to the hospital, including the chief information and privacy officer, requesting to see that collateral information.

The hospital had 30 days under the new Personal Health Information Protection Act to provide, in writing, where that information was and whether or not I can have access to it. If not, they had to provide a reason why, and in writing. That was four and half years ago, and I still don't have that information, nor do I have a letter indicating where it is.

Also, under the PHIPA legislation I had a right to correct facts or provide a statement of disagreement on anything that is in my medical record. I'm being barred from making these corrections on the collateral information because they are hidden by the hospital. The IPC, the Information and Privacy Commissioner, has done very little if not relieve their hands of this situation.

I understood from outpatient administration that the notes the doctors take to form their assessment are destroyed, which is also illegal.

I was contacted by the chair of the research ethics committee of the hospital, telling me that the chief privacy commissioner would be calling me regarding my requests. She never called.

When I finally found a family physician, I asked her to refer me to a psychiatrist, but she refused, saying that I would not like her. I found out why she said this, because the clinician who forwarded my name for research without my consent noted on the discharge file that I left because I did not like them, not because the hospital had repeatedly and systemically abused my privacy rights. It was also noted on the discharge file that I had diabetes. I never had diabetes in my life, nor did I then. I asked the family physician to refer me to Toronto to see a psychiatrist if she felt I wouldn't like her friend in Hamilton, but she did not.

In March 2005, I applied to the Information and Privacy Commissioner to file a formal complaint against

St. Joseph's hospital for not complying with the legislation. The IPC did not respond for at least three months. I was told by the registrar that they aren't enforcing the law because the law is new. I was told by the staff member handling the complaint that the Supreme Court decision *McInerney v. MacDonald* did not apply to them. I was sent a letter by another staff member that the transition clause, section 18(7) of the PHIPA legislation, did not exist.

I forwarded the IPC a copy of an e-mail sent to me by the manager of hostels and shelters at the city of Hamilton, indicating that the shelters were free to use blanket consents, violating the PHIPA. I was sent a letter by the registrar and the deputy commissioner. They said they never received the e-mail, despite a record of it being sent.

I was also sent a letter by the deputy commissioner indicating that the shelter was not within the circle of care, and therefore outside their jurisdiction. The person who provided that information was a new manager and lied to the DC during his investigation.

The registrar—yes?

The Chair (Mr. Kevin Daniel Flynn): Marlene, just so you know, you have about a minute.

Ms. Marlene Westfall: Okay. I've got just a little bit more.

The Chair (Mr. Kevin Daniel Flynn): Yes, that's great. I just wanted you to know that.

Ms. Marlene Westfall: Yes, I knew I was kind of getting in on—

The Chair (Mr. Kevin Daniel Flynn): You're close to the edge, but you're not over it yet.

Ms. Marlene Westfall: The registrar got his only information about the shelter from their website. That e-mail and a complaint about the IPC were forwarded to the Attorney General's office and no letter was sent in response. To this day, the IPC continues to tell me to keep requesting to get the information from the hospital, despite the copies of the requests I had sent them in my original complaint. These ludicrous actions by the IPC are incomprehensible and are tantamount to being complicit in violating the legislation along with the hospital. The registrar also contacted my social worker without my consent, where she instructed him to speak to me directly. She had sent a letter to them letting them know how much more anxiety they are causing by not enforcing the act.

I finally had to audiotape the IPC's refusal to allow me the access to my own file to find out what information they were getting about me from the hospital. I was told that the access-to-information legislation did not apply to them.

Staff at St. Joe's urgent care clinic have confirmed that the shelters are providing "shared care." I spoke to the nurse who contacted my family members and she confirmed that they speak to the shelters on a regular basis and that the hospitals keep secret records.

This legislation has an offence clause. I attempted to bring the concern to the Hamilton police. I sat with the

chief and he said that their officers were peace officers and should act on offences, but no officer contacted me after this meeting. I called again and I was told by an officer in the fraud department, "I don't care about your privacy issues." It appears nobody does.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Marlene. That was good time management. You hit the 20-minute mark right on the—

Ms. Marlene Westfall: Oh, my God. I can't believe it.

The Chair (Mr. Kevin Daniel Flynn): Came pretty close to the edge.

Ms. Marlene Westfall: I'm sorry I didn't leave any time for questions.

The Chair (Mr. Kevin Daniel Flynn): No, that's fine. We understand that. I think you were very clear in your concerns, and I thank you for coming today.

LORRAINE McGRATTAN

PAUL HAMEL

The Chair (Mr. Kevin Daniel Flynn): The next speaker today is Lorraine McGrattan. Lorraine, if you'd like to come forward? Make yourself comfortable.

Interjection.

The Chair (Mr. Kevin Daniel Flynn): You've heard it all before?

Ms. Lorraine McGrattan: I know the water and—yes.

The Chair (Mr. Kevin Daniel Flynn): I say it in my sleep now.

Ms. Lorraine McGrattan: This is my brother Paul. He has escorted me here today, and I'm speaking on behalf of my whole family.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today. It's all yours.

Ms. Lorraine McGrattan: It has been quite an experience listening to the physician and then to an actual patient, so this is a family's perspective on the challenges. Hopefully it weaves in through all the discussions as well. Just so you know, my talk is approximately 10 to 12 minutes.

The goal today is to give you insight into a deficiency within the structure of the mental health system and to provide a personal, and likely typical, account of one family's struggle with manic depression, or bipolar. We'll touch on three themes: the health care system and mental health sector; the family; and the patient, who is my brother—not this brother. We'll try and limit the emotions from this presentation and focus on what we perceive as flaws in the structure.

The initial onset of the disease was apparent to the family. It was clear to us that our brother, who was approximately 22 years of age at the time, was bipolar. We had absolutely no experience in dealing with him and the disease, so we managed by not answering phone calls. We avoided contact, isolating him from our lives. This was not easy, as we're typically a close family. Our

urges for medical help were ignored, and of course there was offence by our gestures to my brother. The illness projected him into a state of homelessness and a lifestyle that we could no longer ignore. Navigating the resources to help us help our brother was unfamiliar territory, challenging and time-consuming. We learned about COAST, we learned about forms 1 and 2, confidentiality, assessment, patient rights, hospital systems, police services, the justice of the peace and much, much more.

So the flaw here is the lack of early diagnosis. For years he weaved his way through society with his highs and lows. There was police intervention and COAST monitoring his behaviour. In fact, we had a form 2 issued on him. We walked and drove the streets looking for our brother to finally have the police bring him to hospital. To our horror, the hospital did not contain him for the 72-hour observation. We were deflated. Why would the family seek help through the justice of the peace and why would he grant a form 2 if there is no just cause? Again, this cog in the wheel is just another opportunity for the patient to fall through the cracks.

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Flaw number 2: If a JP issues a form 2, it should be a mandatory three-day observation and should also mandate family consultation. With three forms over the past many years, there was never opportunity for family consultation. It gives the family time to inform and educate the health care professionals of his current state and history. He is very intelligent and can suppress conversation just long enough to fool those around him. The other problem during assessment and treatment is that the medical professionals don't really know what they're aiming for because they don't know the patient, and the family does.

Flaw number 3: Patients who are fully manic do not seek medical help. In fact, they resent it and are usually angered by the family's interference. They are manic and justify their thoughts, their actions and the voices that they hear.

We had 20 years of undiagnosed episodes of mental health problems. What repercussions did these have on our brother? It has been impossible to maintain any consistent lifestyle that he deserves. As a teenager he was handsome, very bright, an honour student, a talented musician and an artist—and as I'm reading this, I'm thinking he was very entertaining and humorous and had much more potential to have a rich and full life, like most of us in this room.

Instead, over the years he has become an expert in living frugally because his mental episodes have not allowed him to sustain a lifestyle of employment and lasting relationships, not to mention a family of his own. I thank God there are no children involved who are affected by his bipolar episodes. Rather, I truly wish he could have reaped the rewards of having a family and children of his own. I wonder as well, what cost is there to our society and health care system when his treatment is mismanaged?

Fast-tracking, after 20 years of drama ending after a heroic escape from an ambulance traveling down a main street en route to hospital, our brother was finally clinically diagnosed and treated. For the last 10 years he has been medically managed and has had an adequate lifestyle, but below the standards of most of us. He gained the confidence to become self-employed as an interior painter and has functioned in society as a neighbour, friend and family member. Thankfully, both my parents and my brother were able to enjoy the benefits of normalcy from the medication before they passed away. More recently, something went horrendously wrong.

It's important for you to understand when I say he was a responsible person who fully understood his mental health issues. He religiously attended medical appointments to monitor his lithium levels and took his prescription religiously. That was for 10 years.

Two years ago, we noticed tremors in his hands and encouraged him to seek medical attention. Finally, after a few attempts with his family physician to explore the problem, the tremors were strong enough that he could barely pour liquids from one container to the next, let alone paint. His physician finally took notice after ignoring his inquiries as the tremors went beyond the hands and were very obvious. He ended up in hospital less than two days later—he had a medical appointment, so two days later—with toxic levels of lithium. Imagine a man over 200 pounds on a stretcher with full-body tremors, confused, forgetful and enduring weak bladder function. He was quite entertaining through that experience as well. It was determined that he had 40% function of his liver, a damaged kidney and thyroid. His once pearly whites are crumbling and to date he has feet and leg ailments due to swelling and other drug-related side effects since his episode.

We were fearful that he had Parkinson's. However, my sister-in-law, who is an RN, informed us that the tremors are a common side effect of lithium and not likely Parkinson's. I blame the doctor for not listening to the concerns of his patient and for not identifying from the blood results that his levels of lithium were toxic. The question now is, how can someone who is monitored routinely become toxic?

The professionals immediately eliminated lithium and for weeks he suffered the withdrawal, and I know it was disturbing to witness. Sadly, the mania was present almost immediately. He was confused and had severe memory loss. As a family, we were very saddened and shocked by his setback. He was discharged with follow-up appointments to monitor his new medication. In short, the patient didn't like the side effects of the drug or the talks with the health professional. He decided to stop going to the appointments and therefore further slipped into a state of manic depression.

Again, as a family, we noticed almost immediately and tried to notify the health professionals at the hospital. They were not eager to learn of this setback nor would they allow me to speak to his psychiatrist due to issues of confidentiality. In fact, they referred me to the family doctor, the very person who mismanaged his care.

Flaw number 4: When he stopped attending the appointments, that was the first flag that he was likely going to slip into a manic-depressive state. What did anyone do at this point? Absolutely nothing. Who would? The family doctor? He's too busy, and it's out of his hands now. The psychiatrist? No, my brother was set up with bridging. Bridging? No, he's 52 years old, and if he decides he doesn't want to go to an appointment, they can't force him. COAST? They have to wait until he has three strikes against him. I was relieved when he received trespassing and harassment notices because the strikes were working in his favour. Lastly, my brother? Not likely—he feels great. The only positive reinforcement and advocate is the family, whose opinion, understanding of the history and knowledge of the current state are not considered. It was shocking how ignorant the people were of his condition and history. With each admission to hospital, the assessments would start at square one, with no concern for history, no understanding of baseline, minimal involvement with the family physician. Again, when you have a family involved every step of the way and their intentions are clearly constructive, involve them. It's like a childhood saying, when a sibling is complaining to the parent and the parent says, "Are you trying to get him into trouble or out of trouble?" Clearly, most families are trying to get their loved ones out of trouble. The system focuses on the minority who might take advantage of the state of mental illness.

Flaw number 5: So here we are in a dilemma, and I approached the family physician, who talked with my brother on a number of occasions, tried to visit and was well aware from a number of incidents that he needed help now. The physician called COAST, and not just once, to bring him to hospital. COAST did an assessment at his home based on their own criteria, and decided that he was not a threat to himself or others, so they did not bring him into hospital.

Flaw number 6: How is it that they can override the judgment of the patient's family doctor, especially after a brief conversation? Please know that COAST is an asset to our community, but I did not approve of their behaviour in this situation. Because my brother eluded his doctor, the doctor could not issue a form 1 as he hadn't assessed him within seven days. That is absolutely ridiculous. Are you protecting the patient from the one bad doctor who may be taking advantage of the patient and his or her state of health? The doctor's intervention would have expedited the resolve and prevented many personal and stressful hours for our family.

Back to my point about who will help my brother, the system is not prepared to take the lead. It more than likely always falls back to the family to advocate on behalf of the patient, and usually against the patient's wishes during the bout of mania. Luckily for us, we have repeated the cycle a few times and can expedite the process and shorten the length of time that our brother is able to further ruin his life by making inappropriate decisions while ill. This includes blowing away an inheritance that could have set him up with a home and a

stable lifestyle; apologies in his wake of mania to those offended by his lewd or crude behaviour; behaviour that would turn his usually pristine apartment into a laboratory of experiments and mass destruction unlivable even for a rat. In fact, during this episode he ended up getting a motel because his apartment was a health hazard—and you have pictures in front of you of his apartment. Really, of all of us in our family, he's the tidest.

Families: For families trying to help the patient, the experience is unbelievably frustrating. The major roadblock is around confidentiality. I ask the question, why is the mental health sector much more likely to pull the confidentiality card out of their back pocket? On a surgical ward, a maternity ward or a medical ward, family assistance is encouraged. We are to believe that mental health should not have stigmas, yet the health professionals stir up much secrecy and stigma with their insistence around privacy for the patient. As an employee at Hamilton Health Sciences, I understand and fully appreciate the importance of confidentiality, but it appears that the mental health care workers use it to the extreme, that it works against the patient's best interests.

My next question is, how can you isolate and protect a patient with mania—someone who hears voices—to be their own advocate? They have the mentality of a young child in terms of decision-making. This is an opportune time to welcome the family to assist in their care. Ideally, the messaging or the mindset of the workers should be to encourage a partnership with families. At some point in the patient's treatment, they are very likely to welcome the help of their family. In fact, they're often quite relieved.

An example might be—and this could have been used in our case back in December—"We're letting you go home on a new drug, but we can't really monitor you as closely as we would like. Perhaps someone in your family or a friend can come on board to help you with your care." In our case, that individual could have alerted the health care worker directly, and they could have intervened and had him hospitalized immediately.

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What would this partnership have avoided over the last few months? Damage to his new vehicle—which he shouldn't have been allowed to drive, but who would alert the MTO?—loss of income; family and friends' stress and alienation; public nuisance; embarrassment for everyone; meeting with the justice of the peace; two to three visits by COAST; four to six meetings with the family doctor; visits to the police station; police intervention on two occasions; patient transfer services; a trespassing notice from Hamilton Health Sciences; multiple episodes of extremely bizarre behaviour; conversations and so on; rebuilding his life; and all the apologies. He's tired and exhausted from trying to pick up the pieces now. I invited him today, but it was too overwhelming. He returned to his home just last week and is back to following up with his appointments on an outpatient capacity.

As his only advocate, what are we to do if this happens again when he's 60 or 70? I'm so worried for him

and not always able to help him. Mostly, I'm growing so tired of fighting the system after 30 years. It's a losing battle, but how will he manage without family? Imagine climbing into a warm bed with a stomach full of Thanksgiving dinner, all the while knowing your loved one is, through no fault of his own, asleep somewhere on the street?

Now we have issues of benefits. He has lost six months of income, which is cutting into his savings. He is eager to get back to work but unable to stand or paint due to the side effects of his current drug. Also, his teeth have crumbled, so his first impression, especially when quoting paint jobs, will not be the best one. Who will help pay for the dental work? Do I make inquiries with legal aid to help him in determining if the blood levels were obviously above normal for years? Is the doctor accountable here?

My brother is in no condition to fight. He's tired and raging a battle of his own. Do we help fight this battle with all the bureaucracy? I've already made inquiries only to receive the usual responses of confidentiality and so on. The last six months have set my brother back significantly. If not for family intervention, perseverance and love, I can't imagine what his situation would be right now.

To conclude, I've talked about the challenges for families when trying to support their loved ones. Some of the challenges include: confidentiality; early diagnosis; navigational resources for families; family involvement during care; gaps and challenges within the network of professionals—for example, COAST, the family doctor and the justice of the peace; keeping patients accountable while under observation or treatment; enforcing a form 1 or 2 that would contain the person for a minimum of three days; and perhaps an appointed specialist to help weave through all the challenges, which include the above and beyond, for example, the benefits and legal aid.

Thank you for the opportunity to contribute and share a typical experience for any family managing manic depression.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Lorraine, for coming forward. I have a brief question; maybe I can ask you. Throughout Ontario—we started off in Windsor, and we spent yesterday in St. Thomas; now we're here in Hamilton—we've heard many delegations come forward and say that the families need to be involved more; that you're really not just treating the individual, you're treating the family. We've also had people come forward—I think one of the previous presenters said that the institution went overboard and gave out too much information about her. Can you talk about where you think that balance between the privacy of the individual and the rights of the family should be struck?

Ms. Lorraine McGrattan: I think there have been a number of opportunities—and please jump in, Paul. I think 10 years ago it could have been documented that the patient welcomes family intervention, and those files

should have stayed with Larry, my brother. But like I talked about in my speech, the health care workers start off at square one, with the patient on their doorstep with the current issues. There's never consideration for the history. So at a time when my brother is of sane mind and body, he could approve our intervention, and that could ride with him so that we don't have to go through all the roadblocks that we have.

Obviously, I listened to the one woman before me who did not encourage family intervention, and that's fine. But if it's documented, that would just save so much time and trouble for so many people.

Mr. Paul Hamel: If I could just add one thing to Lorraine's comment, it wasn't so much that we were looking for information from the medical people, it was hoping that they would listen to us to get some feedback, some background, because there is no ongoing file in the case of our brother.

Ms. Lorraine McGrattan: We've typically got him to hospital and then backed off, and let the health professionals look after him, all the while just sort of monitoring—if you're a bridging nurse and he says no, then it's a flag to really keep an eye on him. So I think we've given him his space for treatment.

The Chair (Mr. Kevin Daniel Flynn): Any further questions? We've got time for one more.

Ms. Sylvia Jones: I have one.

The Chair (Mr. Kevin Daniel Flynn): Go ahead, Sylvia.

Ms. Sylvia Jones: Your comment about the fact that you work at the—was it Hamilton Health Sciences?—and that you see a difference in how health care practitioners deal with mental health patients and their families, and use the privacy more often—did I get that right, that you perceive a difference?

Ms. Lorraine McGrattan: I just work in a health care environment where confidentiality is the utmost with every individual who's associated with the hospital. So I understand the issues around confidentiality, but I don't bring my employment here today.

Ms. Sylvia Jones: No, and I don't mean to suggest that. My impression of your comment was that you saw a difference between if I have cancer and how the family is engaged, involved or encouraged and if I have a mental health issue.

Ms. Lorraine McGrattan: Absolutely. If I was to walk onto a unit, which I've done many, many times because I've had a fellow volunteer or a staff person in hospital—"What room are they in?" and blah, blah, blah. A nurse at the bedside—I've asked questions. There's absolutely a barrier and a difference in the dialogue with the health professionals in the medical field versus the mental health field. Absolutely.

Larry has a friend, or a girlfriend, and I've asked her for feedback to weave into my presentation. Her big issue was all around the confidentiality, the roadblocks, the secrecy, not notifying us that he was even being moved to a whole other hospital. If I was to call any other unit, they'd be very free with that information. So that whole

stigma, I think, is fuelled by the secrecy that goes along with it.

The Chair (Mr. Kevin Daniel Flynn): Thank you for coming today, Lorraine.

Ms. Lorraine McGrattan: Thank you.

OFFORD CENTRE FOR CHILD STUDIES

The Chair (Mr. Kevin Daniel Flynn): We're down to the last two presenters of the day. The first one we're going to hear from is the Offord Centre for Child Studies. Peter Szatmari, if you'd come forward.

1520

Dr. Peter Szatmari: I'm Peter Szatmari. I very much appreciate the opportunity to speak with you this afternoon. I'm a practising child psychiatrist. In preparing for this presentation, I realized I'm the oldest practising psychiatrist [*inaudible*]. I'm also the director of the Offord Centre for Child Studies. What I want to try to do today is outline a little bit about what I see the scope of the problem is with respect to children's mental health, talk a little bit about what some of the solutions might be and then how I think the Offord Centre might be of help to the committee in terms of its objectives.

So just to really emphasize the scope of the problem, I think there is a good recognition that about 20% of children in Ontario have serious mental health and learning problems and 10% of Ontario's children have mental health problems that are chronic and lead to long-term impairment. In addition to that, though, there is a significant and important gap between what we know in the science of children's mental health—the interventions—and the practice; that is, what actually happens in the community.

It's very disconcerting to realize that only one in six of Ontario's children who have mental health problems are actually receiving services from community agencies. Even perhaps more disturbing is that many of the services that are provided are not evidence-based; that is, they don't have an empirical justification. In fact, there are a lot of interventions that are out there that are currently not employed.

We know that in general, when it comes to children and youth mental health problems, parents and teachers and primary care providers, including family doctors, often do not recognize mental health problems in children and youth. They see them in a moral context: These are bad kids instead of kids who have serious health problems.

The World Health Organization has demonstrated clearly that of the top 10 causes of adult disability, five of those are in fact mental health problems like schizophrenia, bipolar disorder, obsessive-compulsive disorder, substance abuse. But we have to realize a terribly important finding that's come to the fore in the last couple of years, and that's the recognition that 50% of all adult mental health problems actually begin prior to the age of 15 years. And not only is it mental health that we're talking about, but educational underachievement

and physical problems go along with mental health problems. These do not separate out and segregate independently among our children and youth.

There are really important long-term outcomes associated with mental health problems in children and youth. I've listed on this slide a number of those outcomes that are related to attention deficit hyperactivity disorder and disruptive behaviour disorder. You just have to look in the newspaper on any day of the week and you can see columns about individuals caught in these kinds of predicaments and have to realize that at the source of those predicaments are mental health problems.

Mental health problems also have a significant impact on physical illness in adulthood. There's a very strong relationship between early depression and mood disorder and later cardiovascular disease. There's an increasing recognition that asthma and respiratory problems are linked to early anxiety disorders. And obesity, which of course is an epidemic and is becoming a serious health problem in the community, is in fact related to early anxiety and mood problems as well.

Now, we know that there are public health, community-based population interventions that actually can make a difference. An important one is supporting the development of children prior to school entry. The Pascal report and the possibility of a full-day kindergarten is, I think, a very important step in the right direction. We also know that population-based parenting programs for certain children at risk can make a big difference in terms of later behavioural difficulties. The Ontario government has made a very large investment in early intervention in children with autism spectrum disorder. No other province in Canada has done, I think, as good a job in terms of that implementation, and we know that makes a difference. Finally, we know that mentoring programs, either within schools or in the neighbourhood, like Big Brothers Big Sisters, for example, can have a very positive impact.

But that is not going to answer all the questions. I think if somebody were to ask me what are the four most important needs that Ontario needs to come up with in the next decade or so, I'd list these four.

One is a new estimate of what the prevalence and needs are of mental health children. People talk about one in five children having a mental health problem. You may not realize it, but that figure comes from our group. It comes from the Ontario Child Health Study, which we did in the early 1980s. So those data are now 20 years old, and I think we need an updated set of data on what the prevalence and needs are today.

We need much earlier identification and intervention through collaborative partnerships with schools and community mental health agencies. These are two different ships that are floating in the night, often separately, and they need to be able to work much more closely together.

We need more resources for that 10% of children and youth with chronic and severe mental illness—and you've heard, I think, people talk all day about bipolar disorder, schizophrenia, homelessness etc. That is a

significant health problem that we just don't have the resources for, and the interventions I've talked about that work are more population-based and aren't going to address those with the most severe types of problems.

Let me tell you just a little bit about our centre. We're a research institute based at McMaster University and McMaster Children's Hospital. We're the originators of the Ontario Child Health Study, which really was the first and I think still the most important epidemiologic study of mental health problems in children and youth in North America. We're a multidisciplinary centre, and we do not only world-class science but we also have innovative and evidence-based knowledge translation approaches. In other words, we realize that it's not only important to do science but actually to get the results of that science out there into the community, to the people who need to have that information so that they can make a difference in the lives of children and youth.

Along with my colleagues, I've thought about a number of ways we at the Offord Centre might be able to help the work of this committee. I've taken the three objectives from your mandate and tried to list them under those. I think we have expertise in determining the mental health needs of children and youth. I mentioned not only the Ontario Child Health Study, but also the early development instrument comes from the Offord Centre. That EDI is now used all over Ontario to monitor the readiness of children prior to school. It's also used in many provinces across Canada and is now being used internationally.

We're also a leader in the use of preference methods to understand the service preferences of parents, youth and service providers. Not everybody wants the same type of service. Families, service providers and teachers have different preferences. What we tend to do now is give everybody the same intervention, the same set of services, not really tailored to the needs of the consumer. Our group has really been able to devise interesting and important ways of determining consumer preference to guide that intervention.

I think we're also very good at identifying effective, evidence-based programs that might be published around the world but that may not be known to the community in Ontario and being able to identify interventions that are effective for children and youth.

I've talked about the possibility of a new Ontario Child Health Study. I think this is a possibility, and I think it would be quite important. That data, as I mentioned—the previous data—is over 20 years old now, and Ontario is a very different place today than it was in the early 1980s, when we did the Ontario Child Health Study. We need to think about estimating mental health needs from multiple perspectives. We need to understand much better what community resources are, not only the formal community agencies, but also the informal supports and resources that are available, like volunteers and families. We need to be able to monitor change over time so that as we introduce community-wide programs like a full-day kindergarten program, we need to be able

to evaluate whether that's making a difference in the long term.

I think we can also help the committee identify effective community-based interventions for children and youth. We have special expertise in parenting programs, all the way from parenting infants to parenting teenagers, which, God knows, is a difficult thing to be able to do. We've done extensive work in preventing family violence. We've done a lot of work in peer mediation techniques to reduce bullying. We've developed a number of anxiety and depression prevention programs that are delivered within schools and out that seem to be effective.

1530

I think too that we can leverage existing opportunities. So, for example, for a number of years now we've been scanning the research literature around the world to identify the best and most important and clinically relevant interventions that are being talked about and are being evaluated. We write up a very brief summary of those interventions and that research evidence and make it available primarily for parents, but also for teachers and family doctors and front-line clinicians. Those summaries are available in English and French, and we have plans to translate them into other languages including aboriginal languages. We've piloted many of these in family health teams in Ontario. You'll see within your packet some of those small information pamphlets about anxiety disorders and behaviour disorders in children. These information packages are also available for free on our website.

Let me leave you with what I think is a sobering thought. This comes from a report from UNICEF: Of the 29 OECD nations, Canada ranks 21st in child well-being, including mental health. I'm sure you'll all agree with me that that is really an unacceptable statistic as it currently stands. We all know—you know this—that the social and economic future of this province depends on the current mental health of its children and youth. The one thing that we all want is a better future for our kids. We strongly believe that part of that better future lies in science and research and getting that research out to the right people at the right time when they actually need it. We very much look forward to working with you in ensuring a better future for our kids.

The Chair (Mr. Kevin Daniel Flynn): That's great. Thank you, Peter. Great presentation. There's probably time for one question from each party if we keep it brief, so let's start with France.

M^{me} France Gélinas: Thanks for your presentation. I was just curious to see if your centre had studied or looked at—there was a suggestion that we implement screening tools in our schools—let's say, at grade six and grade seven—where we would screen all the kids for mental illness, with the view that lots of it is not being reported, is not being picked up, so we need to be more proactive. Have you studied it? Do you have an opinion?

Dr. Peter Szatmari: We've certainly looked at the possibility of how to deliver mental health programs in a

high school setting, because you're right, that is an age, at the end of primary school, where a lot of mental health problems really become difficult and manifest. If you institute a screening program, you need to have an intervention that addresses that targeted population. That intervention could be quite expensive and could require a lot of resources; it could be resource-intensive. The approach that we've taken and that we think has better promise is in fact improving the mental health literacy of teachers. So we're going into a high school in this city, for example, and we're having frequent meetings and contact with high school teachers on a face-to-face basis, talking to them about: What do mental health problems look like when they present in school? What are the interventions that the school can do as a whole to reduce stigma, to reduce bullying, to have more inclusive programs? How can we identify the resources in the community that those kids need? They might need a mental health clinic, they might need a family doctor, they might need counselling of some sort so that the school can serve as a resource pool. We think that that approach might be better than a screening tool that targets and identifies a large population of kids and then we're not really sure what to do with those kids, and it might be stigmatizing.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Peter. Maria?

Mrs. Maria Van Bommel: In one of your slides you talk about anxiety and depression prevention programs for children and youth. As we've been doing our hearings in the last few days we've heard a lot about the fact that there seems to be a saw-off at the age of 16, so anybody younger than 16 doesn't seem to get the focus or the attention. You talk about prevention programs. What have we got in the province in terms of programs, not only for prevention, but once depression or anxiety presents itself in children under 16? Is Hamilton the only community that has the opportunity to have some kind of programming for that? What happens across the province? Do you have any research on what is happening across the province on that kind of thing?

Dr. Peter Szatmari: I think it is fair to say that for kids who have a diagnosable mood disorder or an anxiety disorder, there are two interventions that we know work. One is what we call cognitive behaviour therapy. It's a set of sessions—between 10 and 15 sessions—involving a child or youth, himself or herself, plus the parent, or it can be delivered in a group setting where they have a structured behavioural approach to address the cognitions that are anxious and the mood-inducing cognitions that make kids depressed.

We know that works. That's not being used in Ontario. The training programs within community mental health agencies don't really have the personnel, I think, to be able to deliver a lot of cognitive behaviour therapy intervention. A lot of places do—I don't want to generalize to "everybody"—but certainly, the training programs that we have available don't train mental health professionals in the latest evidence.

That's why we think it's so important to get the evidence out there that's being produced. The new science that's being produced in the children's mental health field is amazing, and often it takes 10 years to get it out there. We think we need to expedite that process to make it much more rapid so that people can learn.

Mrs. Maria Van Bommel: But how would we expedite that?

Dr. Peter Szatmari: There's very little money for this kind of knowledge translation process. We do this website; we do these pamphlets. It costs us money. We have to take it out of our budget. There's no place we can apply to get sustainable funding to be able to provide this kind of information to the community. It's one thing we would love to do, but it's difficult.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Peter. Sylvia?

Ms. Sylvia Jones: I want to go back to the comment from France on improving the mental health literacy of teachers. Tell me the logistics of that. Would that have to happen right at the teachers' college level, or is that an opportunity that can happen with professional development?

Dr. Peter Szatmari: Both. My daughter has just graduated from teachers' college. She had a great program. She went to OISE; she was there a year. I'd say to her, "Okay, Claire, sweetheart, what did you learn about children's mental health today?" "Uh...". And she works in an inner-city program. She has taught in the inner-city program. That's point number one.

But I do think the best way to do it is with your feet on the ground running; that is, you get the mental health professional and the experts into the school on a Friday. You have a full day and you just have a dialogue. It's that face-to-face interaction and personal relationship that I think will make the biggest difference, and if we can harness that and begin to systematically apply those kinds of relationships between service providers, teachers, academics and scientists, that could be really an exciting way to lift the mental health literacy of certainly schools, but of the community as well.

The Chair (Mr. Kevin Daniel Flynn): Very good. Thank you very much for coming, Peter. I remember Dr. Dan.

Dr. Peter Szatmari: You do?

The Chair (Mr. Kevin Daniel Flynn): From my days at the children's aid society in Halton. He was quite the guy.

Dr. Peter Szatmari: Right. He was.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today.

Dr. Peter Szatmari: It has been five years since he passed away, but we keep his memory alive as much as we possibly can. Thank you very much.

The Chair (Mr. Kevin Daniel Flynn): And so we should. Thank you very much. For the committee, that is our last delegation of the day, as it turns out.

The committee adjourned at 1538.



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ISSN 1918-9613

**Legislative Assembly
of Ontario**

First Session, 39th Parliament

**Assemblée législative
de l'Ontario**

Première session, 39^e législature

**Official Report
of Debates
(Hansard)**

Thursday 18 June 2009

**Journal
des débats
(Hansard)**

Jeudi 18 juin 2009

**Select Committee on
Mental Health and Addictions**

**Mental Health
and Addictions Strategy**

**Comité spécial de la santé
mentale et des dépendances**

**Stratégie sur la santé mentale et
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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

SELECT COMMITTEE ON
MENTAL HEALTH AND ADDICTIONSCOMITÉ SPÉCIAL DE LA SANTÉ
MENTALE ET DES DÉPENDANCES

Thursday 18 June 2009

Jeudi 18 juin 2009

*The committee met at 0906 in the Days Inn, Kingston.*MENTAL HEALTH
AND ADDICTIONS STRATEGY

The Chair (Mr. Kevin Daniel Flynn): Okay, ladies and gentlemen, we'll call to order. Thank you very much for attending this morning. We're going to get the meeting started.

CAMERON STEVENSON

The Chair (Mr. Kevin Daniel Flynn): Our first presenter this morning is Dr. Cameron Stevenson. Dr. Stevenson, if you'd come forward.

Dr. Cameron Stevenson: Where would you like me to sit?

The Chair (Mr. Kevin Daniel Flynn): Any chair that's not occupied is yours. If you want to grab some water there, feel free.

Dr. Cameron Stevenson: Yes, I will.

The Chair (Mr. Kevin Daniel Flynn): As we've travelled across Ontario, everybody has been getting 20 minutes. You can use that as you see fit. If you could leave some time at the end, we've found it's better if we can get into a little discussion, some questions and answers, if you have time for that, but it's not necessary.

Dr. Cameron Stevenson: I did circulate to the committee about three weeks ago a background history of what's happened in psychiatry from the asylum time of the 1950s to the present, because I have lived through all that and practised through all these times. I'm very much aware of the significant changes that have occurred. That, I've already sent to the committee, and there may be questions arising from that document as well. I brought another document this morning, which is more focused on the local situation.

To give you my background, I graduated in medicine in 1955. I practised general medicine for three years and then entered training in psychiatry, and have been in that branch of the profession since. I have now done private practice for the last about 20 years. Previously, I worked for 30 years at the Kingston Psychiatric Hospital, 13 years of which I was the medical director and the psychiatrist-in-chief. I've actually worked in all the institutions in Kingston, including the Kingston General Hospital, Hotel Dieu and the former Institute of Psychotherapy, and have visited most of the penal institutions in

this area at one time or another. So I have a broad range of experience.

The reason I wanted to make a presentation is because I'm very concerned about the situation currently with regard to the delivery of mental health care. It's in serious trouble. Physicians throughout this city continually remind me that they cannot get psychiatric assistance, and when they do manage to get a patient into the hospital and the patient is discharged, the patient is not followed by the psychiatrist but is turned back to the general physician, who really doesn't feel capable of carrying out the directions that the psychiatrist in the hospital has provided them. This is a problem.

I had a phone call just last week from somebody very close to the head of the department of psychiatry, who asked me—she's a physician—if I would please take a patient of hers. I said, "Look, I'm in the process of trying to retire. I've reduced my caseload now to about 20 patients." The word was that she can't get help either, and she's closely aligned with the head of the department of psychiatry. That indicates there are some problems. Her story was that if she sent somebody to the outpatient clinic, they only see them about 10 times and then they drop them. The kind of patient she was talking about was somebody who needs long-term follow-up—not a serious case, but who needs long-term continued supervision, and that's not available.

What's happened in Kingston in the last 15 years or so is that we have lost half our psychiatric beds. We used to have three facilities to which we could admit patients. We're now down to one unit of 34 beds in the Hotel Dieu Hospital in Kingston, which was under threat recently of being reduced to 24. I'm very reluctant to send patients to that unit; in fact, I've only sent one patient there in the last three or four years, because it's a melange of all kinds of psychiatric disorders. You have a great mixture: Some are people who are quite ill and behaving in an ill fashion, and some are people who need quiet and calm. It has strange echoes, vague echoes to what the asylum used to be like 50 or 60 years ago, because you have these people being quite upset and not under control.

In order to get out of that unit to a more suitable place, they have to apply to the Providence Care Centre, mental health division, for admission. They refuse to take any patients directly unless they've been screened by the Hotel Dieu unit. This is a problem.

Kingston has over 40 psychiatrists, but I can tell you there are only about eight who are in private practice,

four of whom are very selective in what they take. There are two people only doing so-called psychoanalysis. There's one person doing only post-traumatic stress disorder. There's one person only interested in psychotherapy and nothing else. That leaves about two or two and a half general psychiatrists taking patients directly from the community.

The problem is, there is a financial arrangement that applies particularly to Kingston. Nearly all of the university-appointed staff operate under the alternative funding plan, which guarantees an income regardless of what they do. They collect, at the moment, around \$239,000 a year. That's to cover the clinical work, research and teaching that they do. That applies across not just psychiatry but all of the departments in the medical school. The consequence has been that because they have their money regardless of the clinical work, the clinical work tends to be neglected.

As strange as it sounds, psychiatrists working full-time at Providence Care Centre are paid more. They're paid \$246,000 a year for 37.5 hours of work a week. Nobody in private practice can even approach that kind of income, no matter how hard he works. I was talking to one of my buddies who does general psychiatry last night. He cannot make more than about \$170,000 a year working full-time on a fee-per-service basis. So there is a financial disincentive for anybody to do private practice within this city.

We have to get help from universities, and they're not driven to earn income through their clinical work.

I don't know how long I've talked. I've probably talked too long already. I'd better quit.

The Chair (Mr. Kevin Daniel Flynn): No, you're doing great. You've only talked for about seven minutes.

Dr. Cameron Stevenson: Okay. Anyway, the other thing that I'm concerned about and is at the basis of a lot of our problems is the quality of the senior civil service within the ministry itself. I've dealt with these people for over 30 years. We had a dietitian running a \$360-million operation. That was followed by a teacher from North Bay who took over her job. That was followed by an accountant who came from the Management Board of Cabinet, and they wanted a position to put him in so they put him in that. He had no knowledge of psychiatry.

The last position that was responsible was in 1971-72. He was the last psychiatrist, the last person who had any knowledge of the system. From that time onwards, it was either hospital-administrator types or—there was a nursing director who was put in for about six or seven years prior to the dietitian taking over. There's a lot of trouble coming from that level because the people who are running it and are responsible for the system really don't understand what it's about.

The other problem that's occurring more and more is that the psychiatric positions are being displaced from any administrative control, and that control is now in the hands of people with a master's of health administration—executive directors and so on—and that's fine. I worked in a senior management group at KPH for 13

years, and myself and the director of nursing were the only two of six people in that committee. I can tell you that trying to get attention on clinical matters was not always the easiest thing to do. They were more focused on anything but clinical care. They were interested in lawns, buildings, driveways, hallways, railings and all the other stuff, but we have patients here; they're the primary purpose for our existence. Let's discuss these matters.

I can remember on one occasion, I wanted a piece of equipment for the clinical laboratory which would have cost \$14,000 and they said, "Well, you'll have to wait till the end of year. If there's any money left over, we'll let you buy one." This is the kind of attitude. This is prevailing not just in the mental health system; it's probably in the general hospitals now.

Very recently, the temporary lay administrator at KGH told the public—and I was there listening to him—that they were going to cut 14% of the beds at KGH and that the clinical services would be just the same as ever. There would be no changes; it would be just as good as they ever were. That's nonsense; it doesn't work that way.

Anyway, I've said enough, okay? I'll respond to questions.

The Chair (Mr. Kevin Daniel Flynn): Thank you. Let's start with Sylvia, and let me just give you an idea of what time we have. We've got about 10 minutes, so about three minutes for each party.

Ms. Sylvia Jones: Thank you. My question ties into how, when you are working in the hospital settings, are you precluded from carrying on any private practice, or is it just because you have a full 37.5 hours—

Dr. Cameron Stevenson: No. That may be true of the university, but they do their own outpatients anyway within their system. The psychiatrists who are working at PCC are permitted after-hours private practice, and I know two who are doing that. Of course, that can generate quite a bit more money than the \$246,000 they're already getting, and they're doing it. There's always opportunity to do some private practice.

Ms. Sylvia Jones: Okay, thank you.

The Chair (Mr. Kevin Daniel Flynn): France?

M^{me} France Gélinas: Good morning, and thank you for coming. I hear what you say about a lack of psychiatric services for the people of Kingston, but in the document that you have submitted, you also talk about the longer-term support that is usually done by social workers and others. Are those other parts of the mental health system in Kingston working good? Is it solely psychiatry that is missing or is it the full continuum?

0920

Dr. Cameron Stevenson: No, I think it's mainly psychiatry that's missing. We have Frontenac Community Mental Health Services, which I mentioned in my recent report; the details of which are there. They are handling about 500 patients at any one time; there are about 100 staff. There are only four part-time psychiatrists attached to that service, so most of the work is being carried on by social workers, a few nurses and

others. They really service mainly the long-term, chronic patients who would normally, in times past, have been in the psychiatric hospital. They're now placed in the community, and that whole organization looks after that group which has been displaced from the psychiatric hospital. They can function in the community, but with a lot of support.

M^{me} France Gélinas: If you look at the practice of psychiatry, we've heard a lot of people saying, in other instances, that psychiatrists should be working within an interdisciplinary team to make sure that we offer the full continuum of mental health services from primary prevention, health promotion to crisis management, to support to all of this. You seem to not think that this is the way to go, or am I—

Dr. Cameron Stevenson: No, I'm not saying that's not the way to go, but I think too often there's a tendency to—the practice of psychiatry and making proper assessments and diagnoses takes some time and some experience to do properly. To say, "Well, we'll have one psychiatrist and a whole bunch of other people, and he'll see the patient for 15 or 20 minutes and that should be enough to sort the problem out," isn't going to work well. It sometimes takes me many hours before I can conclude what is really happening to this patient and how best to tackle the problem, and nobody else is going to be able to do that. It takes my kind of background to make that kind of decision.

M^{me} France Gélinas: I have been in Kingston before. Most of the psychiatrists I have spoken with before were all very much in favour of the alternative payment plan, but you're saying that this model is actually bringing its own challenges, because not enough of them do clinical work and more of their time is toward research and teaching?

Dr. Cameron Stevenson: I think there's a drift in that direction. It's hard to see that in psychiatry, but I know in other branches of the medical school it's pretty obvious what is happening. For instance, in KGH the radiologists are outside the system. They refuse to be paid this way. They're close in with these people involved in the alternative funding plan, and they shake their heads at how little they're actually doing.

I know that, for instance, in the department of anesthesiology in Kingston the members stop working at 3 o'clock. They only handle emergency cases after 3 o'clock. Any elective cases, if they're not finished by 3 o'clock, that's it, the case isn't handled. That's the alternative funding plan at work: They work the hours they're supposed to work, and they work no further. This has caused great delays. One of the members of that department is a pain specialist. I contacted his office in November and was told, "Well, it'll be about 10 months before he can be seen." Fortunately, I phoned about three weeks ago, and they managed to push it forward.

I know another case of a person I was dealing with who needed to be assessed. His assessment required that he get an anesthetic while getting an MRI image done, because he couldn't lie on his back and be comfortable;

he had to be put asleep to do it. He was under a neurosurgeon at that point. The neurosurgeon was told, "Well, he's got to wait a year. We can't possibly fit him in with this current schedule." So there is a tendency to slow down. In a lot of these departments, some of the members do nothing but research and they let some of the other people do the clinical work. So the alternative funding plan does not work well. The University of Toronto's isn't all that good, I know that. The only people I know elsewhere are at CHEO in Ottawa. I have a distant relative who is a psychiatrist there, and he has joined this group. He thought it was wonderful: He could take his holidays and didn't have to worry about making any money. He was given the money right off the top; what he did was his business.

The Chair (Mr. Kevin Daniel Flynn): Helena?

Ms. Helena Jaczek: I want to ask you a couple of questions related to what we've heard as we've travelled around the province.

We've heard from a number of parents of children in their late teens, early twenties, who feel very strongly that although they are relied upon to be part of the supportive network for their child, they don't receive enough information regarding diagnosis, treatment and so on, because the young person has not given consent. So I'd like your opinion as to whether the current provisions under the Personal Health Information Protection Act are appropriate. That's one question.

The second is, parents are also telling us that perhaps the 72 hours of observation—I think it's the form 2 that is completed—is not sufficient, and that they're well aware that their loved one, whoever they're caring for, is able to confabulate or somehow give the appearance of normalcy in 72 hours. So my question is, should that period be extended?

Dr. Cameron Stevenson: The answer to the first question is that under the health information privacy act—anything under the Mental Health Act is excluded from that kind of privacy, and that's not widely known, even amongst the secular hospitals. I've had to talk to a few of them about it. Under the act, for instance, you're not supposed to communicate, without the patient's consent, any information to anybody, but under the Mental Health Act that does not apply. You can raise the questions to anybody, including relatives, friends, and the patient's permission is not required. I don't know how that applies to the teenage group you're talking about, but if it's being done within the Mental Health Act format, that privacy act does not apply. I've actually talked to the commissioner's office about this, and that is a fact. It's written in the act itself. It's clear.

Ms. Helena Jaczek: So, if they're admitted to hospital under the Mental Health Act, PHIPA does not apply?

Dr. Cameron Stevenson: That's right.

Ms. Helena Jaczek: Perhaps some of these cases were still in sort of the emergency—

Dr. Cameron Stevenson: Outpatient.

Ms. Helena Jaczek: —and outpatient, and it was that kind of situation.

Dr. Cameron Stevenson: Well, it's really unfortunate because it does tend to hinder the necessary transfer of information, and I think it has perhaps gone a little bit too far.

I have a stepdaughter who's the principal of a school in Toronto, and she has a son who has a serious problem. He is now in the care of Toronto's Hospital for Sick Children, but he had previously been looked at by the North York hospital. She simply asked for a transfer of the information, and they said, "No. You've got to come in and sign for it." That's impeding health care by putting too many strictures on a transfer of information.

Is there one more?

Ms. Helena Jaczek: The 72 hours for assessment.

Dr. Cameron Stevenson: The 72 hours is a bit confining, and people can, in fact, play games. I sit on the Consent and Capacity Board, and they oftentimes play games there as well. You have to hang on to them long enough so finally they can't behave normally—after more than 15 or 20 minutes, they start to show their illness. There's always a tendency for people to put on their best behaviour and—

Ms. Helena Jaczek: Would you recommend extending the 72—

Dr. Cameron Stevenson: They should extend it. The whole thing is a bit tight.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much, Doctor, for your submissions and for your attendance here today. It was very interesting.

PHILIP BURGE

The Chair (Mr. Kevin Daniel Flynn): While I call forward the next speaker this morning, who's Philip Burge, the associate professor of psychiatry—a member of the audience wanted to know who we are, which is a little unusual but probably not a bad idea. So why don't we start with Maria, and maybe we can just tell everyone in the audience who we are.

Mrs. Maria Van Bommel: I'm Maria Van Bommel, MPP for Lambton-Kent-Middlesex and parliamentary assistant to the Minister of Children and Youth Services.

Mrs. Liz Sandals: I'm Liz Sandals, the MPP for Guelph and the parliamentary assistant to the Minister of Education.

Mr. Yasir Naqvi: I'm Yasir Naqvi. I'm the MPP for Ottawa Centre and the parliamentary assistant to the Minister of Revenue.

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Ms. Helena Jaczek: I'm Helena Jaczek, MPP for the riding of Oak Ridges-Markham and parliamentary assistant to the Minister of Health Promotion.

The Chair (Mr. Kevin Daniel Flynn): I'm Kevin Flynn, the MPP for Oakville. I'm the Chair of the committee and the PA to the MPP for Kingston and the Islands, John Gerretsen, the Minister of the Environment.

Ms. Sylvia Jones: Good morning. I'm Sylvia Jones, the MPP for Dufferin-Caledon, and I'm the Progressive Conservative critic for community and social services.

M^{me} France Gélinas: Good morning. My name is France Gélinas. I'm the MPP for Nickel Belt and the health critic for the NDP.

The Chair (Mr. Kevin Daniel Flynn): Everybody else with us is our supporting cast from the Legislative Assembly who makes sure these committee meetings get held on time.

The floor is all yours, Philip. You have 20 minutes, like everybody else does. We find the mics work best if you're about a foot away from them. You can use that 20 minutes any way you see fit. If there's time for any questions at the end, that usually works better. The floor is yours.

Dr. Philip Burge: Thank you. My name is Philip Burge, as you noted. I'm a faculty member with the department of psychiatry at Queen's. I'm actually a social worker, clinically, and I work exclusively with people who have developmental disabilities and another mental disorder.

I've prepared these brief six or eight—I think there are eight slides on PowerPoint, which I'll try and pull up, but I've given you a copy. I apologize to the folks here that I've got my back to you and I don't have extra copies beyond the 20 that I gave the committee. It's just going to take me a second here, as technology does sometimes.

Just to give you a bit more information about my background, I've been a social worker for over 20 years and worked in a number of sectors, always in Ontario. That includes the children's mental health sector, where I worked for over five years, primarily in the Peterborough area, and I've worked in adult mental health. I worked very briefly in the child welfare sector, which isn't the mental health sector, but I worked there. And I've worked in Toronto, Peterborough and Kingston primarily, and have been at Queen's for the last 12 years.

What I would like to do is just give you some brief background of the population that I'm wanting to speak about today and complement previous politicians and members of the public who fed into previous policies on mental health and addictions, and then talk about just three recommendations.

I'm having trouble here, so I'm going to just abandon ship. Please ignore that. You can probably look on your slides and I'll refer to them. I think you've all got copies.

Thank you so much for accepting me to come today to speak with your committee. By way of background, when I talk about developmental disabilities, I want to note that in the DSM, the Diagnostic and Statistical Manual of Mental Disorders, we talk about mental retardation. That's a term that the parents I work with and the individuals I work with cannot stand. However, that's still the diagnostic term we use, so I'm just noting that that's the population I'm talking about. There are three criteria for people to be diagnosed with that diagnosis: cognitive impairment, usually done through IQ tests; adaptive functioning impairments that are considered to be very significant, also on the various standardized measures; and the age of onset has to be before age 18. This, in Ontario, constitutes approximately 1% to 3% of

the population. We don't have very good monitoring of segments of the population and so the estimates are pretty much used worldwide—1% to 3%.

Eighty per cent of those people with what I will call a developmental disability from here forward have what's called a mild level of this disability. Studies have shown that when we think of developmental disability, or when the public does, they think of people with moderate to severe levels, but most people, the vast majority, have mild levels of developmental disability and wouldn't readily be recognized by us. There may be perhaps people in the room who would have that label in some manner.

You might ask why I would want to come and speak to you about 1% to 3% of the Ontario population. This doesn't necessarily make up a large segment of the population, and you've got far more pressing issues perhaps. The main reason I want to talk about this group, besides my personal and professional interest in their welfare and my work with these individuals, is that they have a high, high rate of mental health issues arise in their lives. By various estimates and studies that have been done in Ontario and internationally—there's a wide range of figures, but the lowest end usually is about 40%. So at any given time, this 1% to 3%—40% of those individuals will be suffering from another mental disorder. They experience the full range of mental disorders from, let's say, the DSM—whether psychosis, mood disorder, anxiety; the full range—and that's been proven, but obviously at much higher rates than the rest of the general public. We've done studies in Kingston and there have been studies, seldom, elsewhere in Canada that have shown that the length of stay in acute care psychiatric units is about the same as for other individuals.

Why is this important? First of all, while they have the same length of stay in acute care psychiatric admissions, when we've looked at hospitals we find that they make up almost 3% of the admissions. So we're talking about 40% of 1% who are making up almost 3% of admissions. Then when we look at length of stay in the psychiatric hospitals, the nine psychiatric hospitals that were surveyed over the years, I believe it was 1999 to 2003, we found that they made up 18% of the population in our hospitals in Ontario. Again, 1% to 3% of people, of which 40% might have a mental disorder, were making up almost 20%; almost one in five of the in-patients in Ontario have a dual diagnosis of developmental disability and another disorder—not to be confused with that other “concurrent disorder” we now use in Ontario, which helps to get rid of confusion. In the past, people thought of dual disorder being an addictions problem and another mental disorder. So we're talking 18%.

When we've done studies in Kingston to look at this in more detail, we've found that when we looked at the psychiatric hospital in Kingston over a five-year period and all the admissions with developmental disabilities, and compared that to a group of people who didn't have a developmental disability, they were staying much longer. What was keeping them there much longer tended to be a

need to move to a higher level of home supervision, residential supervision. If they didn't have a worker in a developmental service agency or an adult protective services worker or a supportive independent living worker or a social worker out in the community, they were also staying longer. So the people with dual diagnosis tend to stay much longer in the psychiatric hospitals.

In fact, in my work that is a really sad situation, when we have to have someone transferred from the downtown hospitals out to the psychiatric hospital because, anecdotally, I tend to see that as a five- or a 10-year stay at minimum, and I don't often see people ever come out. That's because they often are not accepted back by family, who need more supports, and those supports aren't available to keep the person at home; or the agency, if it's a developmental service agency, kind of orphans that individual and gives away their bed to another individual. So we find a lot of people who are stuck in the psychiatric hospitals and it's a very pressing issue.

We've seen Ontario close institutions for people with developmental disabilities. We need the institutionalized people in our psychiatric hospitals who are simply waiting for supports and residential services to have that opportunity to leave the hospital.

I want to turn attention to talk about some policy and access issues briefly. In Ontario we have at last count—and this is from the technical adviser chair of ACTT Ontario—78 ACT teams in Ontario. ACT teams locally, when I survey them, and across other parts of Ontario, will tell me—and this isn't borne out by intense research—their belief is that 10% to 15% of their clients have a developmental disability and another mental disorder. Sometimes they feel a little pressed to serve those individuals and would like some more training. This is, again, an incredibly large percentage of people served by ACT teams in Ontario.

The policy issue that I want to highlight is really that there was confusion in Ontario between about 1997 to 2000 about whether people with dual diagnosis should be served by ACT teams. It wasn't the group that the ACT teams were originally designed to serve when it was a type of team started out of Madison, Wisconsin in the 1970s. However, the document that the Ministry of Health put out some years ago, *Making It Happen*, which I've got here today, cleared up this problem immediately after some consultations that happened. As people in the developmental service sector of the mental health services, we could turn to this document and say, “Page 38 names what is the first priority population and what are the diagnoses that qualify,” and clearly it says, “Dual diagnosis.” Sure enough, that has led to confusion being sorted out.

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People with dual diagnosis need to have other qualification factors. They need to have axis I disorders of psychosis—which is the majority of axis I diagnoses for Ontario ACT teams—or a mood disorder. So they clearly

had to qualify, but having a developmental disability did not exclude them. That has turned out to be an incredible thing for accessing service for this clientele, and 10% to 15% of the ACTT clientele have a developmental disability. That's only one little, tiny part of the continuum of services in Ontario, but it represents up to almost 800 people that are receiving this intensive level of service. And a document produced by the Ministry of Health, not buried in some regulations but actually in the implementation plan and the document that went out to all of the service providers, helped sort that out.

Unfortunately, when we turn to children's mental health, and I know you've had quite involved presentations by the children's mental health sector through the Ministry of Children and Youth Services, children's mental health is in shambles, except when it comes to recent autism initiatives that have usually gone, or have sometimes gone, to children's mental health agencies. We find children's mental health agencies extremely poorly trained to serve our clientele, and unwilling to get some of that training. Because in their policy document, called *A Shared Responsibility*, there's no real definition of which population is served beyond what I've put on the sheet here—some very vague references to age eligibility and some nice statements about serving people with severe and complex needs. We need diagnostic categories to be placed there.

People with dual diagnosis are being sent off to get services from behavioural teams, which exist in most counties, but have two- to three-year wait lists. They are often not being served adequately, and when they do receive services—and some of these children's mental health agencies do better than others, and some actually do focus more so on developmental disabilities, like the Griffin Centre in Toronto. But often what happens is that as soon as the developmental disability becomes evident by those service providers, they're quickly looking to refer that clientele to some other agency, and there really aren't many other agencies that can serve children.

My last slide, of course, would be the recommendations, and I would make some very clear recommendations regarding children's mental health.

Firstly, that they receive a very clear policy document—and it's not just me saying that they have a vague document in shambles. The organization of children's mental health agencies has indicated this, that they're not happy with the document. But I strongly believe, and believe a large sector of Ontario clinicians and family members would say, that people with developmental disabilities deserve to get served by that massive sector that is supposedly for children.

Secondly, I've spoken earlier about the folks who are in-patients. We badly need supportive housing efforts. This isn't just for people with dual diagnosis. For a lot of the people in our psychiatric hospitals who are able to move out, there's a fair bit of management of their psychiatric illness. They've got a lot of the skills; there's just not enough supportive housing initiatives. And you might say to me, "Well, in the last 15 years, the adult mental health sector has become five times bigger in the

community agencies." All those agencies across Ontario that are the adult mental health services, their budgets have increased by about five or six times in the last 15 years. Some of that has gone toward housing initiatives to help bring people out of hospital, but not enough, by far.

My final recommendation is around training. If we're really going to be able to increase services to people with dual diagnosis, we need to make sure that the children's mental health sector and the adult mental health sector can benefit from targeted training activities about how to serve these individuals. Although I said that people may be ill-equipped in some sectors like children's mental health, they definitely have 90% or more of the skills and the experience. They need a little bit of extra knowledge in terms of how to serve our clientele—maybe knowledge of how to use some of their already advanced communication skills specifically for our population—and some information about some more best practices. So we do see a lack of training initiatives at this time.

Really, this comes back to these three recommendations. I hope I've made a compelling case to try and influence you, to influence the other committee members and the ministry to make some changes in terms of children's mental health policy, supportive housing initiatives and training initiatives.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much, Philip. Great presentation. We've probably left time for one quick question and answer from each party, starting with France.

M^{me} France Gélinas: Thank you. Good morning. You did make your point very well, and a point well taken. Would you be able to give me some examples of supported housing for people with developmental disabilities and mental health that works well? Are there best practices out there where those people really get it and make a difference?

Dr. Philip Burge: There are agencies around Ontario that have pockets of these really good practices. Even our local agency, Frontenac Community Mental Health Services, has some very good services. Sometimes what happens, though, is that those mental health agencies are expecting a quick flow-through of people: People leave hospital, will gain skills, and then can move on to less supported types of housing. Often, people with intellectual disabilities, developmental disabilities and another mental disorder need lifelong supports that might really only be two to three hours every other day to help them with some things like budgeting and shopping—some basic supervision. But you kind of have to go to the developmental service sector to see a sector that has some benefits in that area, although it's underfunded and their supported, independent-living-type services have long, long wait lists.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Philip. Liz?

Mrs. Liz Sandals: I just have some technical questions. You've been quite specific here talking about DD. I assume that dual diagnosis would also include autism and a mental health diagnosis?

Dr. Philip Burge: When we get to autism, people talk about that as a spectrum. Within that spectrum in the DSM, they have autistic disorder, and people with that disorder qualify as having mental retardation or developmental disability as well. When we get to people who are on the end that is referred to as Asperger's or PDD-NOS, they typically do not have an intellectual deficit that puts them in that range. They actually are denied for service by and large by 95% of the developmental service agencies, because the developmental service sector of MCSS does not currently include those people as eligible.

Mrs. Liz Sandals: Although they may have quite serious behavioural issues.

Dr. Philip Burge: Exactly.

Mrs. Liz Sandals: So my instinctive reaction is that they also belong in dual diagnosis.

Dr. Philip Burge: Yes.

Mrs. Liz Sandals: Are there stats around autism and its intersection with mental health issues both at the DD end of autism and at the high-functioning end of autism?

Dr. Philip Burge: In terms of Ontario service usage kind of stats, I don't think they exist. We've done surveys of hospitals and whatnot. I'd have to double-check; there may have been. The study that happened out of CAMH in Toronto that looked at a four-year period with the Colorado assessment scale, the secondary analysis of that by Dr. Yona Lunskey, may have pulled some of that out. I have a copy of her paper which I can leave behind, but I don't have them in my brain right now.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Philip. Sylvia?

Ms. Sylvia Jones: Thank you. My question tacks back to access under children's mental health. You mentioned behavioural teams and waiting lists of two to three years. Is that to get assessed by the behavioural team, or is that access to service after the team?

Dr. Philip Burge: That's just for a basic assessment by a behavioural team. Behavioural teams are constructed so there are behavioural therapists always working with a consulting psychologist. In most counties, there will be two to three therapists covering one or two counties, and they will have two- to three-year wait lists. Sometimes they struggle to find a psychologist to supervise them. This service is highly needed and unfortunately is underfunded.

Ms. Sylvia Jones: Are most of those referrals coming through the school system or through GPs?

Dr. Philip Burge: Those teams will accept referrals from the school system, parents, hospitals, MDs, other team members of multi-disciplinary teams. They can do that, yes.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today, Philip. Your presentation was appreciated.

JOHN HOWARD SOCIETY OF CANADA

The Chair (Mr. Kevin Daniel Flynn): Our next speaker this morning is from the John Howard Society of Canada: Dr. Craig Jones, the executive director.

Just for the audience's information, we started this tour in Windsor on Monday. We've been to Hamilton. We've been to St. Thomas and have paid a visit to the hospital in St. Thomas along the way. Along the way, we've been joined by MPP Christine Elliott, Gilles Bisson, Bas Balkissoon, MPP Jeff Leal, MPP Mike Colle, MPP Mike Brown. The Speaker of the House, Steve Peters, joined us in St. Thomas, and today we're joined by staff from John Gerretsen's constituency office. So we've been seeing a real cross-section of Ontario this week.

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Dr. Jones, the floor is all yours. You've got 20 minutes. Use it any way you see fit.

Dr. Craig Jones: Thank you for inviting me. I'm going to open with a little bit of humour—unintentional, but that's the way it works out.

I am the executive director of the national John Howard Society of Canada, which advocates to the federal government for changes to criminal justice policy across the entire criminal justice system, including mental illness and mental health. That is the target for whom this paper was written.

How did it come about? Well, when Susan contacted me a month ago now, something like that, I was in negotiations with a couple of members of Parliament in Ottawa about a similar panel that is touring the country to call on people like me in various regions. So when I got Susan's call, I thought, "Okay, this is the federal panel. Here I go." I wrote a paper for the federal level. So I would almost suggest that you bring Phil Burge back and let him talk for another 20 minutes, because he's got more to say about this that may be of direct relevance to you.

But I can speak to a couple of things. From the standpoint of the John Howard Society as a national institution, the single biggest problems we confront, where mental illness is concerned, relate to stigmatization and continuity of care.

I've drafted a little section on stigmatization in the first section of this. My previous research on mental illness concerned the—I was the integration writer for the southeastern Ontario mental health implementation task force a couple of years ago. We heard from numbers of service providers, consumers and epidemiologists, and the message that came to us again and again was that stigmatization is in many instances worse than the condition itself.

I'll just give you a little anecdote from that period. As the writer for the integration committee of that task force, I was to present to the integration committee on the issue of stigmatization. The day before I was to present, an incident made the newspapers in Toronto. The current Minister of Finance in Ottawa—at that time, he was running for the leadership of the Conservative Party of Ontario—made a comment which got a great deal of press coverage when he advocated rounding up homeless people and incarcerating them. So I went into this meeting of the task force the next morning, and half of

the committee were just dumbstruck by what had happened the day before—I mean, here was a blatant example of the stigmatization of the mentally ill—and of course the other half of the committee were political appointees and friends of that individual, who were not inclined to kick up too much dust about it.

I want to bring to your attention that where we are talking about federally incarcerated prisoners, we are talking about multi-stigmatized persons, the large percentage of whom come to the prison system with untreated trauma, mental illness of some kind, very often a developmental disability, and criminality. We layer on to these people various forms of stigmatization, and then when we release them into the community, which is another issue altogether, we wonder why they fail. We restigmatize them and restigmatize them and restigmatize them.

My argument to you is that we, as Canadians, need to take a hard look at ourselves, and particularly our political elites have to resist the temptation to stigmatize. The example I use in this paper relates to the national anti-drug strategy. I know you didn't draft the national anti-drug strategy, but it's a really good example of stigmatization, maybe not deliberate stigmatization but stigmatization nonetheless.

I'll draw your attention to the text on page 5. When the Prime Minister introduced the national anti-drug strategy in Winnipeg, he said, "If you're addicted to drugs, we'll help you. But if you deal drugs, we'll punish you." You will recall that drug policy and addictions experts pounced on these two sentences as evidence that the national anti-drug strategy, or at least the people who drafted that speech, either fundamentally misunderstood or misrepresented the nature of drug addiction and substance abuse, particularly the nature of their complex interactions and the proven uselessness of punishment. So I call on you to take up the challenge of resisting the political imperative to stigmatize for short-term political gain. That's my first request to you.

The second thing is that in the preparation of this paper I did a number of key informant interviews across the country, and what we hear from coast to coast to coast are challenges in the continuity of care. In other words, we have in Canada some of the best treatment programs available—evidence-based, best practices. We don't have as many as we need, of course; resources are always a problem. But the real challenge is, we have currently in place a mental health system with incentives—that is, at the community level—to refuse care when somebody is released to the community from a federal prison. Obviously, while they're incarcerated in a federal prison, they're under federal jurisdiction. Once they're released to the community, they're under provincial jurisdiction, and this is where the gaps in treatment become unbearable. That is the message I would bring to you today.

I'm sorry I drafted this for the wrong audience, but you might get something out of it anyway. I'm happy to answer questions if I can, and if I can't, I'll simply refer you back to Phil.

The Chair (Mr. Kevin Daniel Flynn): That's great. You've left a lot of time for questions. Let's start on the government side: Maria, then Liz.

Mrs. Maria Van Bommel: On page 6, in the little box, I find a very interesting comment in number 4, where you say, "We're too focused on risk management—we need more early intervention." Can you just elaborate on that particular comment?

Dr. Craig Jones: A comment I picked up from a couple of people across the system in CSC is that over the last 15 or 20 years, CSC has moved increasingly toward risk management and away from rehabilitation. So the emphasis has shifted. The kind of complaints I hear are that front-line social workers, psychologists, psychiatrists, counsellors and so forth spend much more valuable time writing reports and doing risk management assessments than actually delivering services to the people who need them.

Mrs. Liz Sandals: I have a past life as a parliamentary assistant to community safety and correctional services, so let's talk about provincial corrections, where you've got a different scenario. You've got people who are on increasingly long periods of remand and then potentially a very short period of post-remand incarceration. We get everybody first, which means we also have a very high percentage of people who often have addiction or mental health issues or both. Do you have any specific recommendations for provincial corrections, and where we need to go to handle that population that is really more mental health than corrections?

1000

Dr. Craig Jones: Actually, I would refer you to my Ontario policy shop, which specializes in this, but I can tell you that one of the reasons that we take an interest in this is—my Ontario policy shop is in Toronto, off Queen Street West, and they see the same people cycling through the system at an extraordinary rate, as you know, and getting worse every time they cycle through the system. So they may go in for a short period of remand and then they're out; they may go in for a second period of remand, and they've lost their apartment or their place to live, so now they're on the street. If they have an untreated mental disability, every time they cycle through the system, they're probably getting worse or they're picking up various other behaviours; they're becoming more criminalized in the process. So without having deep expertise in that, I would happily refer you to my Ontario policy shop because we have a housing specialist there.

Really, from what I understand, the issue is stability of accommodations, stability of housing. We seem to be able to keep these people, some of whom are quite injured, at a relatively stable state if we can house them in decent accommodations.

Mrs. Liz Sandals: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Sylvia?

Ms. Sylvia Jones: Good morning. I would like you to expand on your comment that as people leave institutions there's an incentive to refuse care at the community level. What did you mean by that?

Dr. Craig Jones: This is what I hear from my key informants across the country, that, for example, here in Kingston, somebody will work up an inmate to the point where they're stabilized on their meds, they're stabilized with a therapeutic regime, they've got a counsellor and so forth, and then they're at warrant expiry or they're under supervision in the community for a period of time. My contacts on the inside tell me stories about spending hours and hours and hours on the phone trying to find somebody in the community to pick them up and care for them, to maintain the continuity of care, and they say to me, "Thank God for John Howard, as one of the few agencies that will actually take an interest in these people." Because the way the system is structured at this time, and you can probably learn more about this from Phil, there is no guarantee to pick up a case from the federal system in the provincial system.

Ms. Sylvia Jones: But where does the incentive come in, the incentive to refuse?

Dr. Craig Jones: Maybe I've overstated it a bit. In many cases these are very high-needs individuals, so a lot of buck-passing goes on. Maybe "incentive" is the wrong word.

Ms. Sylvia Jones: Or they're at over-capacity, and that's where the challenge lies.

Dr. Craig Jones: Yes. So again, a resource issue.

The Chair (Mr. Kevin Daniel Flynn): France?

M^{me} France Gélinas: It's a pleasure to meet you. I must say that in Sudbury, John Rimore is the executive director of our John Howard Society, and he does phenomenal work. He was very instrumental in bringing the Housing First model to Sudbury, where, exactly what you say, if we can give them stable accommodations, a place to live, then you have something to work from to address the other issues, but if you don't have this then all is for nothing; you're never going to move forward.

I don't know if you have, through your work, specific examples of housing accommodations that work well or of successful transition programs that exist and could become models for us to look at.

Dr. Craig Jones: Yes, we do. We have a very successful housing system in Ottawa, and the executive director in Ottawa is Don Wadel. He is very knowledgeable, and he has been running, I believe, six different houses, 100 different units, for going on 12 or 15 years, very successfully.

The other part of the network that is running housing very successfully is British Columbia. I know you're probably not mandated to go to British Columbia, but they've been very successful at accommodations there as well. So the answer is yes.

M^{me} France Gélinas: How about for transitioning?

Dr. Craig Jones: Both of those are transition houses.

M^{me} France Gélinas: Not transitioning to housing, but transitioning to mental health services. You say that the inmates have a hard time finding community-based mental health services to support them once they're released. Are there examples out there where it works

well, that when a person gets released, there are mental health services out there to continue with them?

Dr. Craig Jones: That, I don't know. That, I would have to canvass my provincial EDs about. Where the best transition happens in Canada—I can't answer that.

M^{me} France Gélinas: Okay. Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Craig. If I could close with a question, one of the issues we've been dealing with—and we've certainly heard from Senator Kirby on it—is to remove the stigma from the entire issue; that it's something we need to do at the national and provincial level. The sentence you picked out as an example of the stigma was interesting. It says, "If you're addicted to drugs, we'll help you. But if you deal drugs, we'll punish you." I don't usually stick up for the Prime Minister, but on this one, I would think that the average Canadian would read that and say, "Yes, I agree with that." Could you expand on that a little bit? Why is this sentence an example of what we need to do about stigma?

Dr. Craig Jones: The sentence sets up a dichotomy between dealers and users, but the reality on the street is that most users deal in order to support their own habit, so there's not a distinction between them. The sentence aspires to create the impression that there are these, if you will, drug kingpins who ride around in stretch limousines and who make the big money, but those are such a small minority of drug dealers in the entire system. The vast majority of drug dealers are themselves small-time dealers dealing to support their own habits. That's why.

The Chair (Mr. Kevin Daniel Flynn): Okay. That makes some sense. I know that people in the field of addictions, when they hear somebody who maybe confesses to kicking drugs, point out that there's a big difference between a drug addict and a drug abuser. Do you see that with your clientele, people who are truly addicted to drugs or people who choose to do drugs, or is it all really an addictions issue?

Dr. Craig Jones: That's a very good question. I can give you a three-sentence answer, and I can give you a three-volume answer. The fact is that the vast majority of so-called illicit drug-taking in Canada produces no problems for the users themselves. They are casual, for example, marijuana smokers. I've read peer-reviewed literature that argues that even if we were able to cure every heroin addict in Canada, it would make no dent in the overall demand for heroin in Canada because the vast majority are what's called "weekend chippers," and they're not addicted. They just occasionally go out and get a hit of heroin and bliss out for the weekend. You see? So there's a lot of mythology and misunderstanding around drug use and drug abuse.

I can say quite categorically that the vast majority of drug users suffer no consequences from that drug use in their life. It might be a weekend thing, it might be something they do after work. All the attention is drawn to drug abusers because they're the ones who develop criminal lifestyles, who cycle in and out of the criminal

justice system, who break into your cars and so forth. That small minority of people, for example, who live on the Downtown Eastside of Vancouver are, like, 0.001% of all the drug users in Vancouver, but they are the ones who get all the attention because they're the hard-core drug addicts. You see?

If you're interested in this, I refer you to Senator Nolan's senate panel from 2002, which goes into a great deal of detail about these kinds of distinctions, which are usually obliterated in popular conversation, table-talk conversation, around these things.

I have to say that the Prime Minister and the whole national anti-drug strategy has only deepened the mystification and the myth, not only around drug use and drug abuse, but around the role of the criminal element in it.

The Chair (Mr. Kevin Daniel Flynn): Very good. Thank you very much for your presentation today. That was very interesting.

Dr. Craig Jones: Thank you.

ONTARIO TELEMEDICINE NETWORK

The Chair (Mr. Kevin Daniel Flynn): If I can call the next delegation forward. From the Ontario Telemedicine Network, Stewart Stein. Is Stewart with us?

Mr. Stewart Stein: A delegation of one.

The Chair (Mr. Kevin Daniel Flynn): A delegation of one.

Mr. Stewart Stein: It'll just take me a second to set this up.

The Chair (Mr. Kevin Daniel Flynn): No problem.
1010

Mr. Stewart Stein: Ah. Seems the PowerPoint gods are with me today.

The Chair (Mr. Kevin Daniel Flynn): With the gods on your side you have 20 minutes to use any way you see fit. If you could leave some time at the end for some questions, that would be great. The mikes work generally better if you're about a foot away from them.

Mr. Stewart Stein: Okay, thank you. This is appropriate.

So thanks very much—

The Chair (Mr. Kevin Daniel Flynn): You can move the mike if you want to.

Mr. Stewart Stein: As long as you can hear me, that's good.

Thank you very much for allowing me to present to you today. I really appreciate the opportunity. I'm Stewart Stein. I'm the manager of mental health and addictions for the Ontario Telemedicine Network. My role is in developing the strategy for increasing utilization of mental health services over the Ontario Telemedicine Network. I'm going to tell you a little bit more about us.

The Ontario Telemedicine Network plays an important role in facilitating access to mental health services for patients and providers in Ontario. I will delve a little bit further into this to explain exactly how we're doing that.

First of all, for those of you who may not be familiar with telemedicine: What is telemedicine? This photograph that you're seeing on the screen right now is a prime example of how telemedicine works. You've got some kind of health care provider sitting at one end and you've got a patient—or patients and spouses, in this case—sitting at a remote end, and medicine takes place over videoconferencing, and it's interactive.

We use telemedicine in three primary buckets: what I call clinical, as today we're going to be talking about mental health; education, for the dissemination of information and education amongst folks across Ontario; and also for administrative use, so non-clinical, non-education, just for meetings that people might want to have between remote sites.

About the Ontario Telemedicine Network itself: We're an independent, not-for-profit corporation funded primarily by the government of Ontario. We're an integral part of the eHealth strategy and our key partners include eHealth Ontario, who provide our network over the province, Canada Health Infoway, who also provides us with some funding, and our northern First Nations partner, called Keewaytinook Okimakanak tribal council, who run the KO telemedicine network.

What exactly do we do? We're a membership-based organization, so all the folks who use telemedicine join us as members of the organization. We seek to promote the adoption of telemedicine broadly and we set the standards for the use of telemedicine over the network. We don't actually provide clinical services ourselves, but we facilitate connections between providers and patients or between providers and providers. Some of our services include the deployment of new sites. We provide total training and e-learning. We provide turnkey technology management, which means that when a new member approaches us, we set them up and we hold their hand through the whole process. We provide a scheduling and referral management service and we do bridging, which means that we connect multiple points together at the same time. We also provide a webcasting service.

Some quick facts about us—and I'm just building to the ubiquity of telemedicine currently in Ontario. Last year, we conducted about 71,000 events over the network. I want to be quite clear that when I say "events," we're talking about, especially in the case of clinical encounters—in fact, we did 54,000 patient-to-provider encounters last year. We also provided about 19,000 administrative and educational events. What that doesn't tell is the complete story of 150,000 people participating in those educational events, all over telemedicine. We've got about 1,300 end points around the province, 700 members, and we offer a number of clinical programs.

Two important facts you'll see on this slide is that in providing these telemedicine services, we were able to assist in avoiding \$15 million in northern travel grant costs. So people who did not have to travel were able to be seen over telemedicine and did not have to access the travel grant. It was about \$15 million in savings last year. Also, we avoided over 36 million kilometres in travel, so

you can imagine the impact that that has on the environment.

Specifically about mental health, what we are doing around mental health, there are a number of instances where—and programs that are being offered over telemedicine. These are just a few examples; I'm going to give you some specific examples shortly. People are doing individual and group therapy over telemedicine. MMT, which is methadone maintenance therapy, is being offered over telemedicine. We're expanding into community mental health agencies like the ACT teams, like the Canadian Mental Health Association.

The shared-care model of service delivery lends itself very well to telemedicine. I'll talk a little bit more about that. Adolescent mental health services are being offered. We're connecting with Veterans Affairs to facilitate post-traumatic stress assessments and treatment. And, of course, we're doing a lot of psychogeriatric assessments over the network.

This just gives you a sense of the utilization of the network. I talked about the big numbers. Specifically around mental health, last year we conducted over 22,000 mental health events. A little less than half of those were related to addictions.

This is OTN's view of the mental health landscape and where, I think, we really can add some value and are adding value. I know this is not a complete picture of the mental health landscape as you might understand it, but for me, this represents all the organizations that we're currently engaged with. What you're seeing on the screen are a lot of the Ministry of Health sites, the ACTTs, the CMHAs. We're in all of the hospitals in the province, the psychiatric hospitals, and we're connecting with all the family health teams and, obviously, the primary care providers individually.

There's a large network within our network of community networks of specialized care sites, which are primarily funded by MCSS. We're working with the Ministry of Children and Youth Services as well. We're connecting with children's treatment centres, and there's also the youth justice component and the telepsychiatry component and so on. So you can see that we're across ministries.

Does telepsychiatry work? Yes, it does. There are many examples of this. One specific one that I pulled out was a recent study published in June 2007 that found that telepsychiatry encounters were equivalent to those of face-to-face encounters, in addition to reducing costs. Now I have to say that, in this particular study, the technology used was a little bit older. I know that today the technology would cost even less, so that savings would be far in excess of 10%. So I say it works; patients say it works as well. These are numbers that you don't commonly see in health care—satisfaction rates from patients who are saying they would use it again, that they like it, they were able to see their provider and it was easy to use.

I'd like to provide a few examples of current telepsychiatry initiatives. There's this program that has been

developed by the Middlesex Hospital Alliance and the Chatham-Kent Health Alliance. I'm sure you're familiar with the shared-care model of service, but what we have is a family health provider in the community providing, essentially, the psychiatric services under the guidance of a psychiatrist. This really leverages the resources available.

In this particular case, a nurse practitioner has been substituted for a doctor and is being mentored by a doctor at a distance. This would have been otherwise impractical, if not impossible, without telemedicine. So the nurse is conducting intake assessments, monitoring medications and so on, and the doctor is providing guidance and support for the care plan. The outcome of this is that patients with severe and persistent mental illness are receiving more timely care and getting treatment closer to home. They're not having to travel now. In this particular location, at any point of the compass, somebody would have to travel over 100 kilometres in one direction only to receive services. You're talking about 200 kilometres for one trip, and they're avoiding that by using telemedicine.

This is an initiative that I think is extremely interesting. It's a virtual psychiatric emergency room, again, between Chatham-Kent and Leamington. Interestingly, the budget for this program is only \$5,000 annually. What has resulted from this program is that the need to hold unstable mental health patients in a non-psychiatric facility was reduced by 100% because of the ability to be assessed by video conferencing. Wait times have been reduced from 48 hours to two hours to access these services. Again, patients are receiving timely care with continuity, and closer to home. This model has been so successful that it's being replicated at Grey Bruce Health Services, with 10 emergency rooms, and Owen Sound will be the consulting site for this, and it's soon to be implemented at the William Osler centre, which will be supporting Headwaters Health in Orangeville. So it's a successful program that's being replicated in many places.

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Another virtual emergency room, in partnership with Lakeridge Health, Ross Memorial, Peterborough and Whitby—again, the goal is to improve timely access. This is a relatively new program, so I don't have a lot of results for this, but my understanding is that wait times, which have been anywhere from six months to two years—now patients are being seen within 72 hours because of the access through telemedicine. And you can see some of the other peripheral benefits: Parents are missing fewer work days, children are missing fewer school days, and so on.

Another example—some people call it Claude Ranger in North Bay. What's interesting about this one is that not only is telemedicine facilitating the psychiatrist in Toronto seeing patients in North Bay—we've been thinking mostly about telemedicine over vast distances, but in this particular case there are also some health professionals at North Bay General who are accessing the Claude Ranger

centre, which is only about half an hour away. But you can imagine that if you're a busy physician or social worker, to take that time to travel in a crisis, something that's unscheduled, for half an hour across town—whereas you can simply sit down at your desk and within a couple of minutes be on by telemedicine and providing services would be a huge benefit.

We were just talking about corrections a few minutes ago, and there are a number of correctional facilities that are connected through the Ontario Telemedicine Network. There are some federal institutions that are connected and certainly there are a couple of provincial institutions connected, and we're seeking to connect even more. As you've heard, the typical population, the in-custody population, has many of the same health concerns as the regular population, if you will. OTN is enabling consults, preventing unnecessary transfers, so we're saving costs there, reducing risk to the community. The Consent and Capacity Board can do assessments by video, and timely forensic assessments are also enabled over video conferencing.

In summary, I think the committee should consider OTN and telemedicine key enablers for the delivery of mental health services across Ontario.

Hopefully that leaves us some time for questions.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Stewart. We appreciate that. Let's start this time with Sylvia, then France and Helena.

Ms. Sylvia Jones: Your presentation is timely because when we went to CAMH, one of the messages they were leaving with us was that psychiatric treatment and assessment is a perfect match for telemedicine.

My question relates to the communities that are currently being served by OTN. Is that on an on-call, as-needed basis, or are there structured times when those consults are set up? How does that work?

Mr. Stewart Stein: The vast majority of activity over the network is elective. Although I've talked about some emergency examples in here, most of this is scheduled; hence our referral management and scheduling service which coordinates the effort to bring the two sides together. For the users, it's seamless; for us, it's quite complex. But we realize that and we're trying to make this as easy as possible for people to use, so we help coordinate all the various services that are required to bring the two end points together. So when somebody sits down at a studio in Fort Severn and is connecting to Toronto, they just sit there and it sort of happens automatically.

Ms. Sylvia Jones: When you talk about your members, hospitals in particular, is there an annual fee, a maintenance fee, that they have to cover?

Mr. Stewart Stein: For any ministry-funded organizations or LHIN-accountable organizations, there are no membership fees or set-up costs. For other ministries, there are annual fees, typically around \$5,000 per site. Once you're a member of OTN, whether you're a paying member or a non-paying member, it's an all-you-can-eat buffet. All the services are included. There are no additional costs beyond the annual fees.

The Chair (Mr. Kevin Daniel Flynn): Thank you, France?

M^{me} France Gélinas: I come from northern Ontario, I worked 25 years in primary care, and I've used your services extensively. They work well, but also, being from northern Ontario and having worked in the field for a long time, the need for recruitment and retention of professionals in northern Ontario is always present in our minds. I would say, having used it, that it works well in psychiatry. It also works really well in dermatology. Those little cameras work really well.

But there are a number of grumbings in the north regarding telemedicine, as in clients who used to come to Timmins and clients who used to come to Sudbury are now being seen by somebody sitting at CAMH in Toronto, which means that the volume of work for us to recruit and retain a stable workforce in the north is sometimes a little bit compromised because some of the referral patterns have now shifted through telemedicine. We still need live bodies on site in northern Ontario. I certainly support what you've done. It has done a lot of good work for the people of the north, but I certainly wouldn't want the committee to go away thinking, "Oh, there's no need to recruit and retain professionals in northern Ontario" because of this.

Also, there is screening that is done by the people in the field in mental health. You didn't mention that. It works well for the people who have addiction issues. It doesn't always work that well for people with mental health issues who really think that their neighbours and God are also connected to that little TV. Those people are screened by the people, usually nurse practitioners and nurses, in the field. Those people still have to travel to their appointments, and they will never be candidates for telemedicine just because of the problems that come with their illness, whether it be schizophrenia or other mental diseases that tend to make them leery of technology. I want to bring that in the balance.

I would never do anything that would impede the development of telemedicine. I recognize the important role it plays in the area that I represent. As I say, we've used it, we've learned to love it, but at the same time, we always have to balance this with the fact that people in northern Ontario are Ontarians and they deserve the same level of service as everybody else. I'll leave it at that.

The Chair (Mr. Kevin Daniel Flynn): I'm not sure that was a question.

M^{me} France Gélinas: No. He can—

The Chair (Mr. Kevin Daniel Flynn): I think the answer would be, "I agree" anyway, and the time is up except for one more from the government. Helena.

Ms. Helena Jaczek: I was particularly interested in your child and youth virtual emergency consultation practice. Certainly, as we've travelled across the province, we've heard from parents how frustrating it is to get that diagnosis, that early recognition. I think you said that this was a specific area, was perhaps a pilot that is being conducted. Here's my real question: If you're in every hospital in Ontario, is it possible for a family physician

confronted with a situation that he's perhaps unsure about, a teen behavioural issue, to go to the hospital, say, "I need a consult on an emergency basis for this young person" and have some connection to, say, CAMH and a psychiatrist?

Mr. Stewart Stein: Certainly it's possible. The delivery of the service and how to access it, depending on where the psychiatrists are, can be a little bit more complex. For example, there is a telepsychiatry network. It's somewhat independent of OTN, and it's funded largely by MCYS. You can't access the service through a hospital; you have to go to an MCYS organization or gateway, if you will, to access that. There are certain criteria for accessing it.

There is a funding proposal on the table by the same folks to receive funds so people can access it in the way that you've described. We're hoping that that gets funded so that people can access it, because there's a network of some 70 child psychiatrists who are involved and a great resource to all of Ontario.

The Chair (Mr. Kevin Daniel Flynn): Wonderful. Thank you very much for coming today, Stewart. That was a great presentation. Good news.

1030

PATRICIA FORSDYKE

The Chair (Mr. Kevin Daniel Flynn): Our next speaker this morning—perhaps she can get ready—is Patricia Forsdyke. Make yourself at home there. I'm sure you'll find a clean glass of water, if you need one.

Ms. Patricia Forsdyke: Yes, thank you.

The Chair (Mr. Kevin Daniel Flynn): I think you've been here since we started this morning, so you've heard all the—

Ms. Patricia Forsdyke: Yes, and I agree with much of what has been said. But I will be critical of some points. I will reflect some of my concerns in my presentation.

The Chair (Mr. Kevin Daniel Flynn): Wonderful.

Ms. Patricia Forsdyke: I'm going to actually read it because I think I'll be better off doing that. I've given you all a file; I would ask you to listen to me first before getting involved in the stuff that I've put in the presentation. Basically, I want to make it very clear that my big message here is beds—acute beds and some chronic beds—being put back into the system. The other point I want to make is that—I'm sorry, I've lost my train of thought. I think I'll just read what I'm about to do.

When I use the words "consumer-survivor" it's not meant to be derogatory, because a lot of the people I know call themselves that and I've been involved with them over the years. I wanted to start off by—I've put a lot of material in your packages, but basically this week, for instance—yes, I know what I want to say. I'm not speaking for the Schizophrenia Society. I've been involved with them for three decades but I'm not a member this year. It's simply the structure of the organization that bothers me. I'm not anti- some of the things

they've done; I simply think that it's no longer grassroots, and this is what we used to do to help.

So I'll begin with my presentation. One of the telephone calls I had this week—I was just about to have my lunch on Sunday, and one young woman—I knew her when she was a young woman; this is about two and a half decades ago. Anyway, her friend, who also has schizophrenia, phoned up and said, "So-and-so is in jail." In other words, "What will you do about it?" As far as I'm aware, this person has never been in jail before; she's about 50. She has chronic schizophrenia; she's very paranoid, so I won't mention her name. Anyway, she has gone through the hospital system in the last very short while. I think she has been homeless. She has never been homeless, as far as I'm aware, until very recently. Anyway, she ended up in Quinte jail. So she's an example of the way the system has gone.

Now I'll plow into my presentation.

I'm not here to praise the system of care for the seriously mentally ill. It is derailing and is in for a big crash. I hope that you, as elected officials, listen carefully to what I have to say and act upon it. This mess was not created by one party. It was a long time in the making. If you all survive the next election, you could help to put in place something that might work for the 3% of the population with the most serious mental illnesses. Families and their loved ones will be eternally grateful if you do so.

For three decades I have seen activists who call themselves consumer-survivors aggressively push some very scary agendas. People paid by the system and bureaucrats have supported these agendas, often out of self-interest. You will hear from these people often. Much of what you hear will be dead wrong and very dangerous for the 3% with brain diseases. Some courageous professionals have spoken out against the nonsense but have often been sidelined. Compassion through real understanding would be a step in the right direction. Those consumers who deny that schizophrenia and manic depression are medical illnesses should not speak for those who need medicine to put their lives back on track.

Beware of those who use phrases such as "mental health issues"—you've used it a lot this morning, but you've used it in the right context this morning. I want the word "illness" put back in when people are ill, and I think you were relating to that when you were talking about North Bay. Beware of wellness models, alternative therapies, medicalizations of the mentally ill—these are terms that get used constantly—and anti-medical models. Some of them even say that the stigma is worse than the illness itself. That's absolute nonsense. If you are acutely psychotically ill, the illness is much worse than any stigma.

I came across the following very recently: "Consumers have a personal responsibility for their own self-care and journeys of recovery.... Consumers must strive ... and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness." Where does this come from? Concept 9,

the Mental Health Services Administration, Department of Health and Human Services in the USA. Would they dare say that to someone paralyzed by multiple sclerosis or motor-neuron disease? As Dr. Sally Satel says, "If any psychiatrist followed the 10 fundamental principles of recovery elaborated in the statement from NIH to the letter, he or she would be at risk of malpractice." I've put in the document, *Catalyst*, which has some of these issues in it.

Such utterances have displaced more important priorities like careful diagnosis, state-of-the-art medical treatment and much-needed stabilization for those with these serious illnesses. The silly politically correct talk has so far won the day, and many who have the more serious diagnoses are left to fend for themselves on the streets and in our jails. The mess is clearly here to stay unless families have the courage to speak the truth and professionals and politicians act on that truth.

Am I going too fast, by the way?

The Chair (Mr. Kevin Daniel Flynn): No, you're doing great.

Ms. Patricia Forsdyke: Right. Thank you.

There will likely be many more chronically ill unless someone heeds these warnings. This will place a bigger burden on families and on the long-term-care system. By the way, I did agree with much of what the first psychiatrist said.

Schizophrenia and manic depression must be accepted as no-fault illnesses. Those afflicted have lost in genetic roulette. These are physical illnesses just like multiple sclerosis, and the much-touted recovery model clouds the issue. It would be more honest to talk about stabilization and management, as one does with insulin-dependent diabetes. We must counter the discrimination that leads to dollars and services being denied to the seriously mentally ill. Other serious neurological conditions are obviously treated as no-fault conditions and do not require us to demonstrate that they need health care dollars.

Family blaming is still going on. It now comes with a new twist. I've put an e-mail in your package. This was written by someone who did a survey for the Schizophrenia Society. I was stunned and flabbergasted by this one.

Evidence of the system's failure: The evidence indicates total system failure. We see more mental health courts, increasing police involvement and fewer hospital beds. In droves, the seriously mentally ill are landing in jail instead of in hospitals. The numbers in jail instead of hospitals are mind-boggling. I refer you to a study which I got my hands on a few days ago. It's 110 pages long, and it has diagnostic categories in it. It's a BC study, and it was done by Simon Fraser University. I recommend that you get hold of a copy of it.

Those professionals who are trying to do an exemplary job caring for those with the most serious diagnoses, schizophrenia and manic depression—obviously, there are others—are given little encouragement to do what they were originally trained to do. Many opt to look after the more frequent, milder psychiatric conditions. The

current mantra is that one in four people have a mental illness. Grief is a mental illness when you're going through it; one is not quite okay. But I'm saying that using these statistics in such a way is bound to eventually backfire. Do we give service to the common cold or do we treat pneumonia? Both are important, but the question is, which takes precedence? Ignoring those with schizophrenia and allied disorders places a very heavy burden on society, families and taxpayers, for make no mistake, the public pays one way or another.

I should tell you a little bit about me. Ironically, the person who was talking about teleconferencing this morning—I know the person who does it in Kingston, and he was trained in the same way as I was, in England.

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Someone knowing a bit of my training drafted me to participate on a Canadian Mental Health Association committee in 1980. They were just getting going in Kingston. The money was rolling in for the CMHA at that time. I attended the committee for about six months, then left out of sheer frustration. The organization seemed to know little about psychosis. It was passing around silly bookmarks—"Have a daisy for your mental health." I felt it wasn't responding to people with really serious illnesses. The mess is clearly here to stay unless families have the courage to speak the truth and professionals and politicians act on that truth. There will likely be more chronically ill unless someone heeds these warnings. This will place a bigger burden on families and the long-term-care system.

Schizophrenia and manic depression must be—I'm sorry. I'm repeating myself. I've gone back to page 3. I beg your pardon. I'm on page—excuse me.

The Chair (Mr. Kevin Daniel Flynn): I have you in the middle of page 3, under "My Expertise."

Ms. Patricia Forsdyke: "My Expertise." Yes. I just must have turned it over. I'm so sorry.

The Chair (Mr. Kevin Daniel Flynn): No problem.

Ms. Patricia Forsdyke: I knew if I didn't staple it together, I'd have trouble.

The Chair (Mr. Kevin Daniel Flynn): No problem. You were just about to join the Friends of Schizophrenics.

Ms. Patricia Forsdyke: Yes. I walked down the road and I looked at the Friends of Schizophrenics outfit. It had just started. This was in 1980. It was started in 1979 by Bill Jefferies, who was from Oakville, a very fine man, and Dorothy, his wife. Later, it became the Schizophrenia Society. Bill's main thing was that if anyone ever needed a friend, it was a schizophrenic.

My involvement has lasted almost three decades. I knew that what the CMHA was talking about had little to do with what I thought were serious mental illnesses. The CMHA was driven by ideology and was astonishingly naive. This continues to this day, to some extent. They've changed quite a bit. Just taking a look at who ends up on committees illustrates where the power is and the direction that the government has gone. Those connected to

the CMHA in the early days have garnered most of the funds and power.

Prior to having children, I had been a registered nurse in England and then a registered psychiatric nurse. In addition, I had a background in neurology. I did my psychiatric training in a private hospital but worked later in a state mental hospital. Fraudulent Freud held a lot of sway in those days. I can tell you that psychosis has little to do with which station in life one is born to or what your family did to you. It is the disease that inflicts the wounds.

I sat on multiple focus groups and committees, both at Queen's Park and here in Kingston. I served for years on the executive of the SSO. I was the chapter president here for many years. We helped families navigate the system. Many of their loved ones were rescued from crippling delusional symptoms. Some are now lovingly attending to the needs of their elderly parents, driving them to appointments etc. But initially, it took years to get these people to treatment. We had a lot of skills.

I'll explain to you about why I left the SSO. Bill Jefferies had two brothers with schizophrenia and one of his four children was also afflicted. That started him doing the organization. One of my four children is afflicted with a serious mood disorder. Alas, this did not become evident until five years ago. Again, there is some family history in generations past.

About the Mental Health Commission of Canada: It seems to have little sense of direction and its priorities are questionable. Please see my response to their recent draft. A quick online trip to a recent mental health commission of Britain, which has now closed down—and I've put that in your package—will tell you some of the problems that they find, which are all, in my view, very predictable. Note that the British have allocated 18 million pounds to battle stigma. In my view, the money should have been allocated to address the most pressing problems that they have. Yes, there is stigma, but decreasing it should not be overplayed as a cure-all. There is a naive assumption that removing stigma would take people to treatment. Lack of insight—anosognosia—is the biggest problem in terms of accepting treatment. If you do not think that you are ill, why would you agree to have treatment? I've lost my place again; sorry.

Stigma is not part of this equation. As for the anti-stigma campaign, one beheading on a bus will reverse any public gains they are attempting to make. I don't want to go into that, but I have a lot of views on it.

Prompt treatment seldom happens. Michael Wilson co-chaired an inquiry which stated that only 25% get the treatment they needed. It would be lovely to reduce wait times, but if the system is clogged with the ever-revolving door and lack of trained staff, what can anyone expect?

Those who cannot speak for themselves are at the mercy of those who can. Those calling themselves consumers and sometimes survivors are taking over the system. This other population will continue to hold the high ground along with those professionals who have a vested

interest in following along with such agendas. Those with the very serious forms of these illnesses are often let go by the very teams that are supposed to look after them. I'm talking about them as difficult to serve, who get into drugs and all the rest of it.

Much remains to be known about these devastating diseases, but enough is already known to tell us that these sufferers have been unlucky in genetic roulette. Yet, the mental health commission goes on about prevention. Since we do not understand the mechanisms of these disorders, how can we possibly prevent them? But we should be able to put services in place that will minimize collateral damage.

Society has a lot to answer for, but one's personal biochemistry is not one of them. It should be stated and understood by those planning services that these are no-fault diseases. The commission should stop going on about primary prevention.

Major mental illnesses run in families—I'm repeating myself again. Those who say that stigma—I'll skip that to save time. I think, really, it's like, if one suggested to an insulin-dependent diabetic that he did not need insulin, malpractice suits and culpability would follow, and I think that's one of the main points I'm getting at with some of the people who say "alternative therapies." These are not perfect treatments but they should be continued and monitored.

We've heard reports galore—Heseltine, the Graham Report, which said that the top priority must be for the seriously mentally ill. It got whittled down; nothing happened there. I won't list the reports, but I would like to know what happened to the recommendations that were in Michael Wilson's report, where he co-chaired the report. That seems to have disappeared off the agenda.

My recommendations are:

- Take a serious look at what happens if there are not enough acute and long-term beds.

- Accept the fact that there is no way to prevent the illness.

- Make top-notch medical care the first priority.

- Accept that access—and this is a very important one—to the full range of psychiatric medication is pushed forward because it is cost-effective to keep people stable. These are powerful drugs and patients need close monitoring when they're taking them, and I think that more people should be in hospital when these drugs are given, especially for the first time.

- Revise the Mental Health Act in Ontario. It must be made to work; it's not working.

- Families must be allowed to act in their loved ones' best interest.

I've left a quotation for you. "Along with community treatment orders, we should fund a treatment advocate"—I think this is really important; with the law not working properly, you've got have somebody who's going to try and push for treatment. We've had the Starson case; we've had Vincent Li, and that's going on; and we've had, in this city, Tony Rosato.

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Tony Rosato is quite a well-known theatre person. He had six lawyers; he fired them all. He had several judges. He didn't fire the judges, but they moved on. The last person who represented him, first of all, came in as an amicus, and then he became his defence lawyer. He argued that he shouldn't be an NCR because he wouldn't get a job afterwards. If anyone heard Tony Rosato in court in his own defence, you would have known that this person was a time bomb waiting to go off. He was very dangerous. Anyway, he eventually went to hospital, but he wasn't treated for quite a long time.

I think you need to do something about ODSP. It's ridiculously low.

I think you've got to put more emphasis on not muddling up the walking wounded; that's not a derogatory thing that I'm saying, but people with lesser illnesses. You mustn't muddle them up with the ones who have psychosis, because if you do, we know who is going to lose out. It will be the people with the psychosis.

I leave you with the following quote. It was in an e-mail which was sent to Marvin Ross. He wrote this book. I recommend you get it. I've listed it in your material. This came from somebody who did the quality-of-life study for the Canadian schizophrenia society. I've just included part of the quote. "Framing mental illness, and schizophrenia in particular, as genetically based, biologically driven diseases of a broken brain is actually increasing discrimination and social distance. The unintended consequences of emphasizing the disabilities and deficiencies of the illness and the pain"—I'll stop there. She then goes on to say, "I know that no one involved in the schizophrenia societies believes that they may be contributing to the worsening of stigma and discrimination, but that in fact may be happening." Then she goes on to say, "I think we need to dramatically reframe how we talk about schizophrenia if we are to achieve truly transformative change." That's so stupid. Can you imagine saying this to families of diabetics or of those afflicted with multiple sclerosis?

Families have often lost friends when a loved one is stricken, but this kind of statement is insulting beyond measure. They neither caused their relative's illness nor stigmatized their relative, but sometimes they have had to keep quiet for obvious reasons. I would say that the author of the quality-of-life report is adding to family stress. I assume she got government funds to do this quality-of-life study.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Mrs. Forsdyke.

Ms. Patricia Forsdyke: I'm sorry; I came on with a lot of stuff, but—

The Chair (Mr. Kevin Daniel Flynn): No, no. I think we got your point very clearly. Unfortunately, we don't have any time for questions—

Ms. Patricia Forsdyke: I've left you a lot of material, so you can go through that.

The Chair (Mr. Kevin Daniel Flynn): Our bedtime reading.

Ms. Patricia Forsdyke: This is the last report, may I just say, and I don't buy it. It's got large pictures of people in the report. I don't know why anybody needs a large picture to put out a government report on expensive paper. I'm sorry you won't ask me questions, but please do read what I've given. Thank you very much.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today. It's appreciated.

PENNY PATERSON

The Chair (Mr. Kevin Daniel Flynn): Our next speaker this morning is Penny Paterson. Penny, if you'd like to come forward. You came prepared with your own water. Make yourself at home. Like everybody else, you've got 20 minutes.

Ms. Penny Paterson: I brought my brother John along as well, because this is for both of us and involves both of us.

I'm very glad to have the opportunity to address you today regarding our concerns with the health care system in Kingston's mental health facilities. That's the area that we know. These concerns are from our sister's recent admissions to both Hotel Dieu, our general hospital, and the Providence Care mental health facility.

My talk could be entitled "Let's put the 'care' back into mental health care," or "Putting a human face on mental health care," a good corollary to the last talk, I would say.

As the sister of someone who has had a lifelong struggle with a bipolar disorder, we have a different and much more personal perspective. My sister is now a senior, so that represents over 40 years of a troubled existence. With her aging and the recent separation from her husband, my brother and I have become directly involved as caregivers and caretakers. Our focus is on streamlining treatment practices, earlier intervention, and a more integrated and comfortable process which includes family input.

During our sister's last two relapses, we've had to call on the assistance of the Kingston police as the only means of getting her to hospital. Incidentally, they could not have been kinder or more professional. How can we ensure earlier intervention and prevent her deterioration to such an undignified and irrational state?

A protracted and uncomfortable time in emergency ensued, finally followed by admission to that hospital. After a few weeks and little progress, she was transferred to the Providence continuing care facility. Within a short space of time, she had experienced two sets of health care providers and two treatment approaches and environments. To my knowledge, there was no liaison with the team that supports her in the community—making it now a third set of caregivers. In her fragile and confused state, it was a difficult adjustment, further contributing to her distress and progress. We'd like to see a focus on and discussion of this process. Is there a way to streamline this transition and to avoid so many steps? Ultimately, how can we work together to decrease the duration of the

hospital stay and promote mental health stability for our sister and others requiring care?

Our sister is fortunate in that we are involved in her life and try to keep vigilant, but with her judgment and behaviour rapidly becoming skewed, she is at risk. During her relapses, she became the social worker for Kingston's street people, bringing them into her home. In one week, she spent \$8,000. We shudder to think what could have happened if we had not intervened. She was in both physical and financial jeopardy. I fear she would have been at risk of becoming a street person herself.

It is our hope that we can generate some discussion of increased support for mental health clients in the community. Let's offer some better alternatives to ending up on the street and the discomfort it causes for those involved and for a caring society such as ours.

Are we offering enough support to our mentally ill, once discharged from hospital? How carefully are clients' post-discharge needs assessed? Is client contact sufficient? Should these needs be individualized or minimum standards mandated?

During her last two admissions to both hospitals, all her belongings were lost. Her clothing, jewellery, eyeglasses and personal effects disappeared, never to be retrieved. This occurred despite the fact that everything had been labelled. It's our belief that she was not able to be responsible for anything, let alone her belongings, at this time. There's some comfort in dressing in clothing that fits and is of your own choosing. She was dressed in some pretty bizarre outfits and shoes dug out of a communal cupboard. According to other ward mates, this was a problem for all of them.

I wrote a letter to four staff members with the suggestion that all clients have a labelled bin, kept in a cupboard, where all articles will be kept and accessed by staff when needed, and that valuables be sent home with family. I received no response from all of my letters. I dare say that this plan would save staff precious time, as they would not have to weed through a Pandora's box of a cupboard to clothe people. Perhaps another solution exists, but we do feel this issue needs to be addressed, and I look forward to hearing that it has. I think what was most upsetting to me, having written, I felt, a fairly positive letter, was that I received no response.

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As well, our sister has diabetes, which is a condition requiring special care. When acutely ill, she's not able to attend to her basic needs, let alone any special needs. Her grooming and personal hygiene were neglected, and this aspect of nursing care seemed to be lacking. The positive effects of being clean and well-groomed greatly affect a person's dignity and might even have lifted her lagging spirits and self-esteem. When questioned one day about brushing her teeth, she advised me she'd long since lost her toothbrush and toothpaste. The situation was the same in both hospitals. As a result of several months of neglect, she lost two teeth and has had extensive dental work upon discharge. It's our belief that attention to physical care must be adopted as a part of nursing care

when people are not responsible for their actions and neglect themselves.

When she began to improve, our sister was moved to a ward for people further along in the treatment process. Here, she spent her days sleeping, watching TV or listening to the radio. The family saw no evidence of any programming to assist her in resuming a normal life or enriching her stay. It seemed that efforts promoting interaction with others or exercise programs were sadly lacking. Opportunities for behaviour modification strategies or life-skills teaching were missing entirely. We tried to bridge the gap ourselves between hospital life and a return to her own world by visiting daily, taking her out shopping, etc. She did not seem to have been made aware of places within the hospital that she could take advantage of, like the library, gift shop, canteen and second-hand clothing cupboard. Perhaps she improved more quickly by our involvement. I like to think so, but wonder about those not being visited by family or friends. We very rarely saw other visitors—a void; that needs to be encouraged.

All this left us with a few questions. Is enough care taken to assess an individual's ability to be self-sufficient? Are family members brought into the loop? Is there adequate communication between professionals? Has housing in a safe and supportive environment with ongoing and regular follow-up been arranged prior to discharge? A focus on some life-coping skills, when the acute stage is over, would surely be cost-effective, as it just may reduce frequency of readmission and extend periods of good health.

As you can see, we have serious concerns about the care our sister received during her recent relapse and her subsequent admission and treatment. It is our hope that you will give these matters careful consideration. As stated, our concerns are for all stages of treatment as applied to all clients, as well as our sister. I hope this address will provoke more discussion about the value of earlier intervention, a more seamless handling of treatment, family as an integral connection, improved treatment programming in hospital, and improved discharge planning.

The "human face" mentioned in my introduction doesn't only refer to our sister's story but also to the need to put more humanity into our care of people unfortunate enough to be afflicted with a mental illness.

The Acting Chair (Ms. Helena Jaczek): Thank you so much, Penny, for your presentation. You've left about three minutes per side for questions, starting with the government.

Interjection.

The Acting Chair (Ms. Helena Jaczek): Even more time, Sylvia.

Ms. Sylvia Jones: My question relates to the early intervention. I'm assuming that you're talking about the fact that your sister had to get to the critical or serious stage before any intervention was offered or available. Do you have a suggestion for the committee on how that early intervention could occur?

Ms. Penny Paterson: Well, I think more frequent visits by health care professionals in the community would have picked this up.

Ms. Sylvia Jones: So she was under the care of—

Ms. Penny Paterson: It happened very quickly in this case, so in fairness I don't know exactly how it could have been, but perhaps with more frequent visits by health care professionals.

The Acting Chair (Ms. Helena Jaczek): France?

M^{me} France Gélinas: The question is a little bit personal, so if you don't want to answer it, you have to be very—

Ms. Penny Paterson: This was all pretty personal.

M^{me} France Gélinas: But it's different to volunteer than to be asked.

You mentioned that your sister was diagnosed 40 years ago and lived with the disease for 40 years. Did she live in the community all that time?

Ms. Penny Paterson: Pretty much, yes. We rescued her, as we felt, golly, when she was in her early 30s, I guess, from an institution and got her into the community through group homes and that sort of thing. She has largely been in the community, yes.

M^{me} France Gélinas: And where did she live and how did she support herself? Did she work?

Ms. Penny Paterson: Yes. She was able to in the early years, but not for years. She's been on a disability pension, largely, and she has some independent funds.

M^{me} France Gélinas: Where did she live?

Ms. Penny Paterson: Kingston.

M^{me} France Gélinas: Did she live alone?

Ms. Penny Paterson: She was married, so some of that time she lived alone.

Mr. John Paterson: She actually was in institutions in Ottawa, Guelph, Kingston and Brockville. So she's actually lived in different places in the province.

M^{me} France Gélinas: Where she was in institutions?

Mr. John Paterson: Yes.

M^{me} France Gélinas: Let's say we look at the last two—I think you called them relapses. At that time, what kind of community support was she linked to and through which agency, and how did that work?

Ms. Penny Paterson: She has a psychiatrist in the community and—I don't know the terms, but she has a social service nurse who visits as needed and on a regular basis who she has a very close and caring association with.

M^{me} France Gélinas: And is this a long-standing relationship she has with this nurse?

Ms. Penny Paterson: Fairly long, yes; five years, perhaps. I don't know. Is it that long?

Mr. John Paterson: It's been quite a while. I think they were seeing her about every two weeks before her relapse, but it was within the period of two weeks. It was sort of about two weeks before that Penny and I said to each other, "Things are not going well." It just needs to be more frequent, I think.

Ms. Penny Paterson: And it is more frequent just now.

M^{me} France Gélinas: Were you able to communicate with that nurse that you were worried?

Ms. Penny Paterson: She was on holidays, unfortunately. It's just a situation that developed that fell through the cracks.

M^{me} France Gélinas: And there was no backup while she was on holidays?

Ms. Penny Paterson: Yes, but not by someone who knew her well.

M^{me} France Gélinas: I see.

Ms. Penny Paterson: We've taken from that that we need to see her on a set basis and we will always continue that so that this doesn't happen again.

M^{me} France Gélinas: Now your sister is back in the community, the nurse—we don't know where she comes from—continues to come and see her and she sees a psychiatrist and, I guess, her family physician for her diabetes.

Ms. Penny Paterson: Yes.

Mr. John Paterson: I'm not quite aware of all the three different levels of treatment, the ACT and the—she's at the lowest level that is provided by the—it's through the Providence Continuing Care office. They have a satellite office. There are three levels of care, of which she's on the lowest and has been for a while.

But I think Penny's point is that one of the things is that there's no communication between the different levels, between there, Hotel Dieu and Providence Continuing Care. If there was any communication, it was because of our input and demand for communication.

M^{me} France Gélinas: Other families have told us that they have a hard time being included in the circle of care, they have a hard time knowing what's going on. Has this been your experience also?

Ms. Penny Paterson: Yes. We asked for a family conference when she first got into hospital, and that was excellent. But then, when she came close to discharge, we asked for a discharge conference and were told that no, only one conference is granted. We felt that it would have been very helpful for us to know the doses of drugs, the nature of the drugs. There was a lot of information that we'd have liked to get that wasn't offered.

M^{me} France Gélinas: And you made the request and your request was turned down?

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Ms. Penny Paterson: Yes.

Mr. John Paterson: Can I add also that while she was in Hotel Dieu in the assessment period, she was there for about three weeks. I have personal power of attorney for her care, and I requested—I have my notes at home—eight different times to meet with the psychiatrist, and I finally had to actually say, "Do I have to get somebody legal involved in order to have a meeting with that psychiatrist?"

Ms. Penny Paterson: We actually stormed the door.

Mr. John Paterson: Yes.

Ms. Penny Paterson: We just arrived one day and said—and that's how we saw her.

M^{me} France Gélinas: And you have power of attorney.

Mr. John Paterson: Yes.

The Acting Chair (Ms. Helena Jaczek): That's all the time we have. Thank you very much, Penny and John.

PAUL FINN

The Acting Chair (Ms. Helena Jaczek): The next deputant is Paul Finn. If you'd like to come forward and make yourself comfortable.

If you could introduce yourselves—

Mr. Paul Finn: This is my wife, Denise.

The Acting Chair (Ms. Helena Jaczek): Thank you. So, as you know, you have 20 minutes to make your presentation. You can use it however you wish. If you want to leave time for questions, we certainly do appreciate that as well. Thank you.

Mr. Paul Finn: I just want to say good morning, and thank you. My wife Denise and I, we have six children. Our 23-year old son Luke was diagnosed with schizophrenia around 2005—you'll have to forgive me. I'm not nervous about being here, I'm nervous about what I'm talking about.

That's not the beginning of Luke's story. By the time Luke was eight, we knew he had learning disabilities. Our doctor referred us to the Hotel Dieu child development centre. We filled out all the paperwork and handed it in, and they called and wanted to know why we didn't complete the paperwork. They said, "You didn't write anything down about behavioural problems." Well, Luke has none, or had none at the time. Needless to say, we were very frustrated. We were then told that they would only help children with learning disabilities who had behavioural problems at the same time. Needless to say, we were frustrated. We went to the school board and were told that there was a three- to four-year wait for this to be done, and Luke was in grade 2.

After two years, when he was in grade 4, we opted to do it privately and we found somebody who would do it for us. She did it and she didn't charge us—and I'm probably not supposed to say that because she'll get in trouble because she did it for no charge. Once tested, we had an IEP put in place, and we started to see some progress for him.

By age 11, in grade 5, we saw the first signs of depression. He told us when he was 12 he was tired of being different and he wanted to kill himself. We were stunned and we had no idea what to do. We had lots of bad times and we had some good times as well.

Luke started to come to grips with his learning disabilities when we moved and changed schools. He went from two 20-minute periods of special ed a week to a minimum of one hour a day. He began to improve quite a bit. When he hit high school, as hard as it is for any of your children to go to high school, the transition for Luke, on top of having learning disabilities and depression, made that even worse. Our doctor referred us to

a psychologist, but we couldn't continue with it because of the cost involved, and we couldn't see anyone at child services at the Hotel Dieu.

After a lot of discussion with our doctor, we found a psychiatrist who would see Luke. He was very helpful and Luke made a real connection with him in a short period of time. The only issue was that he was an adult psychiatrist who worked out of the forensic unit at the Ontario hospital, now the PCC. This essentially was a jail; you go through barred doors. We had no idea what was going on and we didn't know what to expect. It terrified us all. It was just not the right place for him, but the doctor there did help him.

Luke worsened, and by the age of 15, in grade 10, he was admitted to the adolescent psychiatric unit at the Hotel Dieu for three weeks. He had to leave that psychiatrist because he didn't have privileges to see him in the hospital in that situation. His time in there was horrible. At Luke's admission, Denise and I were reading the rules of the ward to him. We explained to the nurse who was watching us that he had a learning disability and that's why we were doing it. A few days later, there was a group session and Luke got up and read something to them. We were immediately called in and accused of teaching Luke learned helplessness, that he didn't have learning disabilities, that Luke was faking it and they were going to prove it. They said that they were going to test him again. Our opinion was, "Great," because we knew he'd have to do it later in high school if he wanted to go on.

They started the testing and after one day, they came to us and said, "Yes, he's profoundly learning disabled." What we really wanted to say was "We told you so," but we couldn't. Once they said that the testing would continue with the school board, it took another year and a half to get that done.

At the same time, Luke was telling the doctors that he was hearing voices and seeing things that weren't there. Then the doctors told Luke and us that he was having obsessive thoughts. I realize how hard it is to diagnose adolescents with mental illness because they're up and down, their hormones or whatever, so we accepted that.

Things were going fairly slowly, but he was being seen. He started as an outpatient, at first very sporadically, then bi-monthly and then every week. Things were going really slowly, but he was making some headway. I think some of that slowness was happening because it came to light that Luke had been medicating himself with marijuana.

The week before Luke turned 18, we were told matter of factly that he could no longer be seen by the adolescent psychiatrist and the team members but would have to be referred to an adult one. We objected, saying he was in the middle of treatment, and were told, "Sorry, hospital politics." It took another six months to get him to be seen by a psychiatrist, and after three very short visits she phoned us and told us that Luke was out of her realm of expertise. She referred him and us to the early intervention in psychosis clinic at the Hotel Dieu Hospital.

Once in the program, he finally got the treatment that he needed.

It has not been easy and Luke still struggles daily. There has been a real drain on our family. We can't tell you what it's meant for Luke to get into the program. I'd like to tell you that his story is unique, but I can't.

Through this program, Denise and I have been asked to sit on an advisory committee for the eastern Ontario early intervention in psychosis program, now called the HeadsUp program. I don't know if you know what it is; it's made up of medical professionals, community stakeholders, parents, consumers and, in the beginning, a member of the Ministry of Health. Through the committee, we have seen a small portion of the inner workings of the mental health system and its limitations.

Our family has been very frustrated in trying to find someone who will see us: frustrated with the time frame we got for the initial appointment, frustrated with the time between appointments, and frustrated with the lack of resources available. And guess what? Those same medical professionals and community stakeholders on the advisory committee and the front-line case workers on the ground have the same frustrations.

At one committee meeting we were discussing the need for the program to get its statistics together to present to the Ministry of Health. That's where they get their funding from, as I'm sure you're aware. The representative from one of the regions mentioned that they had a person who did their stats. Another mentioned that they used a certain program to do their stats and perhaps they could share the resources to get the job done. To me, this seemed like a breakthrough; they were making real progress.

The meetings generally last about an hour and a half to two hours. At this particular meeting, the Ministry of Health member was late. When they did come in, all co-operative discussion stopped. When I brought it up again, the first question the Ministry of Health representative asked was if the representatives had surplus budget and were they going to give it back to the ministry. Everyone hummed and hawed, backtracked and retracted. I was told that it is how it was. Perhaps your committee can get a better answer.

Back to the HeadsUp program that Luke attends: It has one part-time psychiatrist—just one. I can tell you that, listening to him give his medical report at the advisory committee, you can hear the stress and strain in his voice, and in my non-expert opinion, he's getting burned out. What if we lose him? Who do I blame? Who do I talk to? What happens to Luke and the 200 other clients in the HeadsUp program? Who do they talk to?

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The stigma that surrounds those living with mental illness doesn't stop with them. There is stigma around those who work and care for those people. I heard the comment that stigma is not the problem. A better term for me would be "ignorance," and that ignorance goes through not only the health system—the ignorance of the people you see at an emergency ward when you present yourself with your son.

As of last week, if you were lucky enough to get referred to the HeadsUp program and were seen within 14 to 21 days, your first follow-up appointment is not going to happen until mid-September. I ask you: Is that right? If a parent or a caregiver had their child seen for an extra appointment, they are now faced with a three-month wait. What options do you have? I can tell you: not many. While you are contemplating the lack of options, you must continue to go to work every day and care for your other children and try to act like everything is okay and wait to have your youngest daughter call you—

Ms. Denise Finn: And wait to have your youngest daughter call you at work every day when she gets off the school bus so you can breathe that sigh of relief—

The Acting Chair (Ms. Helena Jaczek): Please take some time to compose yourselves. I think I speak on behalf of all of the committee to say that we're very grateful for you to have come today. We know it's very, very difficult.

Mr. Paul Finn: So we wait for our daughter to call us to say that Luke hasn't killed himself.

So in the midst of all this and we have a crisis, what do we do? We go to the hospital. We've been sent home and told to watch Luke in case he tries to commit suicide, and, "Come back if it gets worse." I want to say to them, "Why do you think we're here? We're already past 'worse.'"

Luke has now made some large decisions in his life and has made contact with Options for Change, and that's to deal with his reliance on street drugs. His initial appointment, after he made his contact, is two and a half months away.

Someone mentioned ODSP. Denise and I made the decision not to have him go on ODSP because we didn't want him to leave the house and, as our psychiatrist put it, "get his penny from the government and live in a basement apartment." We struggled with that, but just within the last six months we realized that Luke is going to need to be able to support himself, so we had him go on ODSP. At home he gets \$797 a month, nowhere near enough for anyone to live on. I don't know what the alternative would be. I don't know how much more money you would give him. All I can say is that it's probably not enough, but I think it's the best that we can offer, which, unfortunately, doesn't seem to be very good.

I don't want to leave you with the sense that we need a new mental health system; I don't. I can't tell you what it's meant to Denise and I. If it wasn't for the mental health system, I firmly believe that Luke wouldn't be here today. As I said, he was diagnosed around 2005; they never really came out and told us for months and months after he was in the program. One of the things that Luke said to the doctors is, "I've been sick for so long. I don't need you to tell me what I don't have. I need you to tell me what I do have." His doctor said that they would not let him go until they knew what was going on.

When making any decisions, I don't want you to try to walk a mile in Luke's shoes; that's pretty easy. I want

you to lie on a couch or in a bed with your back to the world. Force yourself to do so for an hour or, better yet, put a pillow or a blanket over your head. Don't eat; don't shower; don't talk to anyone. Do it for a day, a week, a month or six months. You'll probably all get very frustrated and get up very soon. You have to realize the extent of what Luke and others like him go through and why they can't get off the couch.

What we need, I think, are more resources to have the best mental health for all Canadians. I think it goes back to how we see ourselves and what kind of society we want to live in.

I'll leave you with a simple thing: Just don't throw out the baby with the bathwater, but do your best to get a bigger bathtub.

Thank you.

The Chair (Mr. Kevin Daniel Flynn): Okay. Are you up for questions?

Mr. Paul Finn: Yes.

The Chair (Mr. Kevin Daniel Flynn): Super. Let's start with Sylvia.

Ms. Sylvia Jones: Thank you very much for coming this morning. I think it's very important that we hear from families.

Based on the timelines, it looks as though your son was diagnosed right around 18, 19. You are obviously very strong advocates for your son, and I'm sure that is helping in his treatment. What I'd like to ask you is, because you were at that age when the privacy issues tend to come forward, did you have any issues with that in terms of getting information from the health care professionals?

Mr. Paul Finn: No, because Luke is more than willing to sign the form. We thought he would be here today, but he couldn't come. He's pretty articulate, and I think that has been a part of his problem. He's fairly bright and articulate and can talk about it and has a deep insight into what's wrong with him, so I think that it's a real challenge to listen to him and believe him, I guess is the only way to say it, because he is that way. What he said to the psychiatrist who accused him of using his learning disabilities when he got up and talked—he snapped at her and said, "I'm learning disabled; I'm not illiterate," and she got her back up, and we got our backs up. So that's where they really went to prove to us that he was faking, and I don't know how they were intent on doing it. But we had no trouble getting any of the information. As a matter of fact, the more we talked—generally, every time Luke would meet with the psychiatrist, we would sometimes get five minutes, 15 minutes, and a lot of that background, that family information, became helpful in getting him diagnosed.

One of the big turnarounds for Luke was when they put him on Tegretol—Denise has a seizure disorder—and he started to improve quite a bit. So that was very helpful.

Regarding your question about whether we're able to get the information, my feeling is, I don't care as long as he gets treated. I don't need to know. I don't want to know.

Ms. Sylvia Jones: But you were clearly playing a very active role in advocating for him, so—

Mr. Paul Finn: In one way we were, but in other ways we weren't. We weren't forceful enough. I didn't become a pain in their ass to make them talk to us. We're not good advocates. I'm not good at getting up and complaining about everything that's wrong in our particular case.

Ms. Sylvia Jones: You did an excellent job this morning. Thank you.

The Chair (Mr. Kevin Daniel Flynn): France?

M^{me} France Gélinas: I, too, want to thank you for sharing your story. It took a lot of courage, but I think it was worth it.

You did mention, in talking to Sylvia, that you were able to get five or 10 minutes with the psychiatrist. Was there any support offered to the rest of your children? You mentioned your daughter calling and saying, "Luke did not commit suicide. He's still here." I can't imagine a child having to report—

Ms. Denise Finn: Through the HeadsUp program, there is support for the family. There's a family education program which we took our children to. We have books available at home for our kids, and there's a little guide that's put out by the Canadian Mental Health Association—siblings living with a sibling with a mental illness—that they've all read and have passed on to their friends. We get Schizophrenia Digest in our home and it's out on the table, available for them to look at and read. They're all very well educated. In fact, our children have turned into these little mental health advocates. It has just been this little fallout that has happened.

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Our daughter, who is the youngest—she has five older brothers. It's her little crusade that people can't use the kind of terms that they use when they're—you know, they think they're just an offhanded comment. For example, her music teacher was explaining something to them recently and referred to it as "very schizophrenic." This same music teacher taught Luke, so he knows Luke's history, and Hannah went, "Excuse me, but that's not the proper term for that word," and he said, "Oh, you know what I mean. You know what I'm trying to say," and Hannah said, "I know what you're trying to say, but you shouldn't be using that word," and he said, "Oh, you know what I'm talking about. You know what I'm trying to say," and Hannah said, "Yes, I do, and I don't appreciate it," and then she said his face just dropped and he went, "You're right; I'm sorry." She said at the end of class he called her aside and he went, "I'm so sorry. I didn't realize what I was saying," and Hannah said, "That's okay. This is just what I do." She said, "I hope you didn't think I was disrespectful," and he said, "No, not at all. Thank you for calling me on it." And that's what they do. I think that's because they've had some education and they know about it.

We know it has been really hard in particular for our daughter to have to grow up with this and make calls like that, but we don't have any other choice.

The Chair (Mr. Kevin Daniel Flynn): Thank you. Are there any questions? Liz?

Mrs. Liz Sandals: Thank you so much for coming and sharing your story. As we've gone from place to place, we've heard a lot of stories about difficulties with children's mental health and adolescent mental health and adult mental health—all these sorts of artificial age boundaries and programs. You've run into another conflict, I guess, between people who are trying to sort out learning disabilities and the education system, plus the health system, looking at mental health, and now you've got addictions layered on that. It seems to be very difficult with teenagers to find coordinated services because you've got all these different systems.

Do you have any recommendations for us about—you talked about not totally throwing out the system, but how would you make this system better so that you don't fall in this service war that you've obviously had to work your way through?

Mr. Paul Finn: No.

Ms. Denise Finn: I think, really, for us it has always just been a lack of resources. There were always people willing to listen once we got in there and got our appointments. If we got to talk to somebody and they knew of another available resource and they could just refer you, and in a reasonable length of time you could be seen by this other person, that would make all the difference in the world.

What Paul just said about Options for Change and Luke—actually, it was four weeks yesterday since he has not used any marijuana. This was a huge decision for him, and he has never, ever gone more than a couple of days in years.

We went with him to talk to his social worker at the HeadsUp program to say that this is the road he was taking and what were the next steps. And she said, "Well, we'll get you a referral to Options for Change." That was two weeks ago, and he sees them at Options for Change on July 3. That's too long. He needs to be seen right away. I know they can't help that, but there has to be a way. That's too long.

So now he's in this kind of limbo stage where he's afraid to leave the house, because he knows the reality is, he has to make all new friends. We live outside of the city. He can't come into the city for the day and just walk from place to place, hanging out with his friends, because he knows the temptation will be there. So he's stuck at home and we're bringing people in to have dinner with him and things like that. And we have to say to them, "You can't have anything on you; you can't having anything with you." We're going through this period right now where, if he could already be somewhere getting the help he needs—but that's not how the system is set up. And once he goes on July 3, when are they going to see him again? We have no idea, because we've lived that in every other facet. We don't know.

Mrs. Liz Sandals: Thank you very much. So your biggest issue is with the wait times and getting access to services.

Mr. Paul Finn: I think, as a comment, and I don't know how you'd ever get around this, the physicians and their lack of humility, in that I say, "I'm going to do the cognitive therapy," and, "No, no, we're going to do psychotherapy." Never will the twain meet, because, "He's his guy and this is your guy, and that's the way we do it." They never seem to get along.

If it was up to me, I'd leave the doctoring to the doctors and leave the running of the medical—you hate to call it "medical," because that infers doctors. Let the people who run the business do it. Experiences would be, in an emergency ward or in emergency—I run a computer help desk at Queen's. If I did my job the way they do theirs, not only would I get fired, they'd throw me out. I don't know how to argue or how to present that case, as difficult—

Mrs. Liz Sandals: There needs to be more consideration for how you interact in a positive way with patients and their families—

Mr. Paul Finn: Absolutely.

Mrs. Liz Sandals: —instead of this, "I'm God. Now just leave me alone."

Mr. Paul Finn: Yes. Call them. We've started to get very good at saying to them, "We disagree with you. What is it that you are"—lots of times, they still get their way, but they've at least informed us of how it is that things need to be done.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much, Paul and Denise, for coming today.

ONTARIO SHORES CENTRE FOR MENTAL HEALTH SCIENCES

The Chair (Mr. Kevin Daniel Flynn): Our next presenter this morning is the Ontario Shores Centre for Mental Health Sciences, if you would come forward: Brian Hart and Glenna Raymond. Make yourselves comfortable. I'm sure we have a clean glass or two around if you need any water. If you don't, let's move on. You've got 20 minutes, the same as everybody else. If you leave some time at the end for maybe some questions and answers, that would be great. It's all yours.

Ms. Glenna Raymond: Thank you. My name is Glenna Raymond and I'm president and CEO of Ontario Shores Centre for Mental Health Sciences. I'm very pleased to have the opportunity to address the select committee this morning. With me is Brian Hart, past chair of our board of directors and a community member.

I appreciate also the opportunity to have heard some of the family stories and patient experiences. They impact so much what we do and our whole approach to care. I also want to share with you that over the last two years at our hospital we've made considerable inroads because of inviting patient stories, patient vignettes, and families to be part of the care environments, and in fact part of the board environment. It's made a huge difference in what we do in our care environment.

Today, though, we'd like to speak more at a system level and to some of the perhaps frustrations or

recommendations that we have, not so much for care and the direct delivery of services at our hospital and from other providers, but more from that system perspective.

We are encouraged by the commitment and attention to mental health and addictions that is being demonstrated at both the provincial and federal levels. The work of this committee, in particular, is an important step in addressing and resolving the challenges that are associated with the growing demand for mental health and addiction services. We commend the government for acknowledging mental health care as a priority.

Our hospital has one core business, and that is mental health care. So we've experienced first-hand the need for a provincial strategy that encompasses the various sectors to guide the transformation of mental health care, and indeed the transformation of the system.

For those of you who might be less familiar with our organization, I'd just like to quickly share a little bit of background about who we are and the work that we do to give you that context.

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Ontario Shores became a public hospital in March 2006, when governance of the organization was transferred from the province to a community-based board of directors. At that time, the hospital operated under the name of Whitby Mental Health Centre. In fact, it was just a few days ago that we unveiled our new name and our new mission statement at an annual general meeting that was standing room only for our community.

Becoming a public hospital really provided an opportunity for our board, senior leadership team, staff and clients to engage in considerable open dialogue with staff, patients, community members, health care providers and other partners in mental health care. These consultation sessions were held both internally and externally to identify strengths and gaps in services and to seek the creation of our organization's core vision, values, directions and purpose. That feedback was very helpful in helping us identify directions for our organization, but it also has given us since 2006 a very broad sense of input into the system on what the gaps in services were.

Ontario Shores provides a broad spectrum of specialized assessment and treatment services to those living with complex and serious mental illness. We serve a range of individuals of all ages and all backgrounds from across Ontario. Our mission is to provide leadership and exemplary mental health care through specialized treatment, research, advocacy and education.

We employ about 1,200 staff, made up of physicians, nurses, allied health professionals and support staff. Our main facility has 329 in-patient beds, and in any given year we typically will treat over 1,000 in-patients and several thousand outpatients. Patients come to us from across Ontario. Our approach to care is very much one that encourages collaboration with all providers and is attempting to put into place the transitions, the seamless care, that we've heard from so many of our clients was one of the gaps.

As specialists in mental health care, we are dedicated to advancing and transforming the mental health care system for the benefit of our patients and all individuals touched by mental illness. We see that our mandate goes beyond the direct service for those clients who are registered patients. We acknowledge the importance of having a coordinated and integrated approach to mental health care that considers a variety of factors, such as equal access to treatment, affordable housing, employment, education, dealing with the stigma of mental illness, and addressing the diverse needs of patients.

There are seven areas, seven recommendations or suggestions, themes, that I'd like to speak to today and leave you with. I'll focus on those seven points this morning.

First of all, serious mental illness is a chronic health condition like diabetes or heart disease. A policy framework and a management strategy that is similar to other chronic disease management models is what is needed. When providing diabetes care or cardiac care, our society has quite a different expectation and approach: concepts such as a client registry, given that there are multiple providers involved in the care; electronic health record tools; self-management supports; drug programs; consumer and peer empowerment; and primary care support. All are important for managing chronic disease and have been well recognized in the models that are currently in use for both diabetes and cardiac care. These are equally important for mental health conditions such as schizophrenia, bipolar disorder and organic psychosis. About half of the people whom we treat at our hospital have a diagnosis of schizophrenia, yet the system around us has not used a similar model to ensure that all of those supports are in place.

The second area where there's room for improvement: A framework and a leadership structure are needed to ensure coordination and accountability, and cannot be left to the individual provider. A champion or a provincial leadership agency or accountability structure is necessary to develop and deploy such a framework. Again, we've seen this in place with other diseases. The Cancer Care Ontario model, for example, has demonstrated a provincial approach to managing disease that could be applied to the delivery of mental health care. This comprehensive approach is required and could help standardize care; ensure equitable access, including wait-time management; deliver evidence-based practice according to research standards; and put in place province-wide measurement and coordination of resources using lead agencies that specialize in mental health care. Again, we have a model in place that was effectively used for other diseases.

Given the complexity and specialized expertise required, we need to ensure that subspecialty areas such as children's services and seniors' services are planned and delivered so that all residents of Ontario gain equitable access to care and services. The amalgamation of mental health hospitals into acute care or into complex care facilities over the past decade, and the 14 perhaps arti-

ficial boundaries created by local health integration networks make it even more important today to put in place some type of provincial coordinating authority or mental health agency.

Provincial-level coordination is of particular importance for forensic services and programming for mental health and the law. There are significant legal system and Criminal Code implications, and Ontario needs to have readily accessible assessment beds and to initiate treatment promptly so that clients who truly need mental health care are not unduly detained in the prison system instead. In addition, given the obligations that arise from the federal Criminal Code law, it's also important that these mental health care services have planning, standard-setting and measurement that is consistent across all providers across this province. Currently, about two thirds of our clients that we see on admission have a legal status that's other than voluntary. This highlights the role that specialized mental health care services provide in the safety of our community.

A coordinated approach is necessary for better client outcomes, wait list management and effective use of resources across the system. If you consider in our organization, just as one example, we have an occupancy rate of over 97%. At times, about 20% of our patients are ready for care in another setting, like a community treatment team, a longer-term-care setting or outpatient case management, some of which we offer ourselves. But on average, at any given time, we have another approximately 30 to 35 individuals who are waiting for admission to our in-patient specialty programs. They wait, on average, for more than 30 days to be admitted, and yet we're full—97% to 100% occupied. A coordinated approach can be accomplished through accountability with a central bed registry, performance management and capacity modelling that a lead agency could oversee for comprehensive mental health care and addictions services. This is probably one of the most significant changes that I believe we need to see in our mental health system.

The third area I'd like to speak to is the broader, if you like, physical or general health system's attention to mental health and addictions. Attention within the health care system overall for mental health and addictions must be elevated. Many of the current Ministry of Health and Long-Term Care initiatives such as the wait-time strategy, the quality agenda, the health human resources initiatives, mandatory reporting for certain indicators and the funding formula work are all functioning to transform Ontario's health system. However, these initiatives are currently designed without adequate consideration of their applicability to the mental health care environment, and we could do much to improve that.

The provincial mental health strategy must provide both direction and investment in health system clinical capacity and provide the tools, resources, clinical expertise, subspecialty care and alignment with other health initiatives to ensure equitable access to treatment across Ontario. Without such, clients who are experiencing

mental health conditions are marginalized within the very health care system that is supposed to be serving them.

A balanced approach to care is needed. We often hear the phrase that "a friend, a job and a place to live" is what consumers want and need, and we certainly agree with that. The expansion of community care, consumer initiatives, peer support, informal care, family care, employment and adequate housing are all important for those individuals who are recovering from mental illness. However, we must also attend to the desperate needs of those who require specialized care and access to specialized services, mental health subspecialty care, to get accurate diagnoses and access to specialist human resources, including medical and other professional staff.

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About 30% to 70% of a general practice physician's normal caseload consists of patients whose ailments are either of a psychological origin or are significantly related to psychological factors. We also know that there's an increase in patients who are requiring mental health care services. In Ontario in the last decade we saw that percentage among mental health requirements rise by around 13%, and yet the general increase in health service demands was only about 4%. We know as well that there's a shortage of nurses, doctors and psychiatrists. For the first time ever in our history at Ontario Shores, we're anticipating a full complement of psychiatrists by next fall with the recent graduating class.

We also know that the presence of co-morbid conditions is well documented. The prevalence of metabolic disorders and cardiovascular disease is much more frequent among those with serious mental illness. Obesity is twice as prevalent in patients with serious mental illness. Diabetes is up to three times more prevalent in this population, and 70% of patients with a diagnosis of schizophrenia die of cardiovascular disease, not their mental health condition. Expert clinical services, in conjunction with informal and social community support systems, are required to assist those with mental illness.

We believe that the provincial strategy needs a delicate balance of attention to four dimensions working in harmony: first, diagnostic and specialized clinical resources and improved capacity; second, specialized human resources, including medical and interprofessional caregivers; third, a focus on legislative, regulatory and policy initiatives; and fourth, consumer, peer and community resources.

The fifth area that I'd like you to give some attention to is to be able to leverage coordination and active involvement across many ministries, such as health, justice, children and youth services, housing—we could have listed probably all of the ministries. The impact and implications of mental health conditions cannot be addressed for individuals with illness, for their families, for society or for our economy without the participation and contribution at a provincial level of many ministries. Government needs to find ways to coordinate efforts across all of its departments as well as ensure identification of lead visible accountability for mental health in Ontario.

At a national level, finally, alignment with the national agenda and a strengthened research focus is important. The national agenda is emphasizing attention on things like stigma, the volunteer social movement, empowering clients and embracing recovery thinking. All of these are necessary elements of a mental health strategy. However, without significant attention to transforming how services are delivered, which is the provincial agenda, and the scientific basis for treatment and recovery, which I see as a shared agenda, we will not advance mental health treatment, recovery or indeed prevention.

There's an urgent need for investment in research, both in basic sciences and applied research and knowledge mobilization. Provincial and federal infrastructure funds are required to support this.

I'd like to thank you for the opportunity to speak with you today. Ontario Shores Centre for Mental Health Sciences champions and supports the efforts of patients, professionals and policy-makers to ensure that individuals with mental illness have access to care and the opportunity to fully participate in society.

The Chair (Mr. Kevin Daniel Flynn): That's great, Glenna. Thank you very much for your presentation. We probably have time for one question. You're first up, I think, France.

M^{me} France Gélinas: I only have one?

The Chair (Mr. Kevin Daniel Flynn): The whole group only has one. You have the question for the entire panel.

M^{me} France Gélinas: Oh, no.

I really like your suggestion under number 2, "A framework and a leadership structure are needed to ensure coordination and accountability," and some of the leads for the function of what that would have to do. I would like—and I only have one question so I'll make it a long one—to see how you see that. What would that look like? You made reference to Cancer Care Ontario. Is this in separate agencies from the government? Because then you come back with point 5, where you—is it point 5?—where you talk about needing to put all of the different departments of different ministries together to be successful. So I take it from this that you see this coordinating agency focusing on mental health being separate from the bureaucracy of the government.

Ms. Glenna Raymond: Yes, I do. I think those are two separate suggestions, comments, that we're making today. The lead agency or structure, I believe, can be separate from government. It needs to put in place the structure and the tools such as capacity modelling, bed registry, standards for assessment, evidence-based practice, wait-time management, those types of things. That would be the task or the focus of such an agency or a lead accountability council or group.

That's different than, but needs to be complemented by, some initiative within government that helps the various departments of government ensure that they are well-aligned and working on the same outcomes. For instance, the legal branch, the forensic services, the children's services, the health ministry—all of those have a huge

impact on recovery and the successful provision of care for mental illness. So how government treats that internally—I don't presume to make any suggestions. As a provider, I see the impact of having several different ministries contribute to or co-operate—or be in competition—in terms of the outcome of the services. The lead agency has a different type of function, in my suggestion, in our presentation to you. Have I made that clear?

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for your presentation. Unfortunately, the time has expired. Do you have a closing remark?

Mr. Brian Hart: I could just add one comment to that. From a board perspective and as a community contributor to this, I could say that we had a rather unique opportunity here when the old Whitby was divested from the government in order to start fresh. It became very clear to us as a board, right from day one in this, that our involvement was not with this hospital as four walls and a particular silo within the health care system; that if we were really going to do our job as a board, we had to look at the full spectrum of mental health services. We couldn't just look at our entity and talk about maximizing the efficiency and the procedures within that. It was really the whole mental health system that was important, and we had to play our part in making that whole system as good as it could be.

So it's a philosophy that we've adopted ourselves, on the board and within the corporation. We've even brought that into the new foundation that we started. We now have a hospital foundation which can actually donate money to other agencies which help out with mental health patients. We've seen it ourselves; we've seen the requirement to talk about the whole mental health system. Now it's just sort of the intransigence of the whole system to make it move forward. It's that sort of static inertia that we have to try to overcome in doing that.

Glenna has brought forward some of the ideas that could happen legislatively and collectively to help with that, but I think we require that desperately.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Brian. Thank you very much for coming today. Thank you, Glenna.

CANADIAN COUNSELLING ASSOCIATION

The Chair (Mr. Kevin Daniel Flynn): Our next speakers this morning are from the Canadian Counselling Association. We've got Barbara MacCallum, the executive director, and Robin Cameron, the Ontario anglo-phone director.

Make yourselves comfortable. If you need any water or anything, I'm sure we've got some clean glasses there for you. Like everybody else, you have 20 minutes. You can use that any way you like. If at the end you could leave some time for questions, that usually works well. The mikes work well when you're about a foot away from them. It's all yours. Thanks for coming.

Ms. Barbara MacCallum: Thank you very much, and thank you for the opportunity. My name is Barbara MacCallum, and I'm the executive director of the Canadian Counselling Association, and this is Robin Cameron, who represents Ontario anglophones. I would like at this time turn the presentation over to Robin.

Ms. Robin Cameron: Thank you very much for having me. Barbara and I were laughing on our way up to the podium because I think she thought I ditched her, which I did think about.

Two pieces before I start: One is that I won't be following exactly the document we've handed out, so I apologize. You're probably tired. You've been here at least for this morning; maybe you've been here longer than that.

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The second piece is that this will be a team effort. I'm very new to the executive of the CCA and what I do not know about them could easily fill this room. I expect the reason I got on the board in the first place, let's say, is because of my involvement in counselling and the counselling profession, advocacy for clients and the protection of the public, and mostly my advocacy for the mental health profession. For the last 10 or 15 years, I've been running workshops, in the last 10 years on the issue of compassion fatigue and the effects of the work on the helping profession. I've had the opportunity to travel all over Ontario and speak to helping professionals, in which I would also include doctors, nurses, counsellors, social workers, a variety of people who actually offer the services, our resources, to clients—and how that work does affect them.

Part of this work that we're doing is also advocacy for the helpers themselves. I think what you've been hearing about is that we greatly rely on having other resources to refer to. Without that, we're kind of all in trouble, so I hope one of the advocacy pieces today will be to support the other groups that have been here as well, like Ontario Shores.

I'll read a small bit of this presentation. If you have any questions, I'm quite comfortable to go ahead. I'll just read this for a minute and then you can ask me anything you like.

The Canadian Counselling Association is in its 45th year as a national and bilingual organization. We're dedicated to the enhancement of the counselling profession in Canada. In fulfilling this mandate, the CCA promotes policies and practices for the provision of accessible, competent and accountable counselling services throughout the human lifespan.

CCA currently has over 850 members in Ontario and over 3,200 members across Canada. These members practise under a variety of titles, such as counsellor, counselling therapist, psychotherapist, and creative arts counsellors, which can include art, drama and music. Many of us are trauma specialists, marriage and family counsellors, school counsellors—which might include elementary, high school or university—career counsellors, substance abuse counsellors. Our list is long and varied.

Because of the diverse skills of counsellors, they are able to work in agencies that provide counselling to children and adolescents, adults, couples and families. Workplace stress, financial difficulties and similar kinds of problems often lead to depression and anxiety and contribute to family conflicts. We are a service readily available to people. Working with people affected by mental health, addictions, chronic illness, death and dying are examples of areas in which counsellors work. Many counsellors also work with perpetrators of domestic violence as well as people affected by abuse. Through that, we also try to do our part to contribute to prevention of those problems through advocacy and educational initiatives.

Recognizing the significant growth of the number of counsellors in various public environments and in private practice, in 1984 the CCA actually established a credentialing service for its members called the Canadian certified counsellor program. This is how I came to the CCA. As a private practitioner, I was really looking for a way to offer my clients a place to go if I do anything wrong—I sort of think our clients have a right to that—and also a place where they can go to ask questions, and a way for me to have a group of people who are like-minded and involved in research and doing the practice of counselling as well. This provides a non-statutory certification process that is available to all CCA members who wish to apply and who fulfill very specific qualification requirements. Our goal is public protection.

There will be more detail on the certification process, if you're interested. Feel free to get in touch with us if you have any questions.

We're proud of our programs, which aim to protect the public interest and ensure members deliver excellence in their standards of service. This is really important to maintain in a regulatory environment as well, and I think that's one of the roles of something like the CCA: to make sure that the professionals have a place to stay involved, continue to do professional development and sharpen the saw, so to speak.

At present, as you are aware, the counselling profession in Canada is not regulated by a statutory process except in the provinces of Quebec and Nova Scotia. We also believe that many counsellors in Ontario will fall under the auspices of the 2007 Psychotherapy Act and be registered with the title of registered psychotherapist and/or registered mental health therapist, and our members will welcome the opportunity to be regulated under the new college.

We're pleased that the Legislature is taking a comprehensive approach to reviewing how the mental health of Ontario's population can be improved. However, we believe that improving a society's mental health is more than simply expanding access to Ministry of Health-funded services.

Individuals with serious and complicated mental health issues such as depression, anxiety or eating disorders often present first to their family physician or at an emergency department. The nature of these conditions

often necessitates treatment that cannot be provided by acute health care facilities. Counsellors play a vital role in helping clients mitigate the effects of such issues and also in helping them learn to cope with their symptoms of distress.

Since many organizations lack the funding or infrastructure to provide more than six to eight sessions of therapy or counselling, clients who require more intensive long-term care for issues such as childhood sexual abuse or addictions may fall through the cracks. Brief therapy and one-off physician visits can be very helpful for uncomplicated issues but do not meet the needs of clients in serious distress or chronic crisis, and the shortage of practitioners who offer these services means that clients wait or do not receive the help they need.

One of the benefits of having counsellors who are trained, although not qualified to diagnose disorders like psychologists or physicians, is that they know when to refer. For example, if a student presents with psychotic symptoms to me, in my role as a counsellor at Queen's, I may not be able to diagnose them, but I do know that it falls well outside the experience of a depressed individual who might come and see me. At that point, I'm really scrambling to find services to which to refer them. I believe you heard a little bit about this earlier. It's also very nice if we can follow the client to make sure that the referral has happened, and we try to do that at our service but you can imagine that also adds to the wait when you're trying to make sure that you're following up with someone to make sure that they were referred, but we like to do that when we can.

One way to greatly enhance the services counsellors can offer—and I have no idea if you're even the group to say this to, but I'll just put this in there—would be to refer directly to a psychiatrist, at our clinic especially. Somebody may wait four to six weeks to see me the first time and often, when the student comes and sits in front of me, I can't believe that they've waited. We have a crisis counsellor. We do have as good of an intake program as you can have if somebody is in crisis, but they have to say so. They have to say, "I can't wait four to six weeks." Our admin staff are fantastic. If they notice a hesitation in a student's voice, they'll ask, "Are you sure? Would you like to see someone today?" But people are incredibly resilient at times or they don't want to say it; they feel proud. I am stunned sometimes by the person who's waited six weeks to see me and then to have to tell them that they may be able to see a psychiatrist in six months—maybe—but I first have to refer them to their GP. If they present their symptoms seriously enough, they may get referred to the psychiatrist.

We are incredibly fortunate here at Queen's that we run a comprehensive service, so we have physicians, we have a couple of psychiatrists who are lovely and we have a great nursing staff and a wonderful admin staff. We have a cross-cultural counsellor, which is fantastic, because talk about students who fall through the cracks. You're going to a professor to ask if you can have a little

more time for an exam, and your professor may not actually know that you're from a country where there's a war going on. So you can imagine how this adds to a client's distress who may actually have acute PTSD and be trying to get treatment for themselves, but also be grieving, worried for family members, and it sort of goes on and on.

Again, when they see their doctor, they really do have to make sure that they're able to advocate for themselves. The doctor may only have five minutes. Some of our doctors see dozens and dozens of students in a day, so they really do have to sort of be able to snap right into it and say, "This is what's happening to me."

Our counsellors typically have two years of graduate level training in mental health issues. This leads to another issue, and that's the issue that's prevalent in our health care system today: There are shortages in competent and accessible services for mental health in Ontario and there are inequities or misunderstandings with regard to qualifications that are exacerbating these gaps.

Agencies in the system will often only hire counsellors who are registered with a statutory regulated body. Despite the fact that many, if not the majority, of counselling programs across the country have mental health counselling as a major focus, graduates from these programs are often unsuccessful at being hired within medical institutions such as hospitals and clinics. You often see this difference between people with a counselling master's and people with, say, a master's of social work. Social work is well recognized in Canada and particularly in Ontario. I have a master's in counselling. I think I was told even by the CAS in Ontario that I would be hired if I had a BSW, but not with a master's in counselling. I found that kind of shocking, given that I had two full years' experience and a master's rather than—anyway, some of the people I talk to say that's a little bit frustrating and it means that there's not as much access to qualified professionals, although we are very lucky that social workers are registered and we have their help too.

1210

We have great hope that once the new College of Psychotherapists and Registered Mental Health Therapists of Ontario is functioning, this issue will be somewhat resolved, but only if counsellors and their training are embraced by the system. The government's action to regulate the practice of psychotherapy through the 2007 Psychotherapy Act was welcomed by our organization, but we are keen to see the legislation implemented. We would urge the government to move quickly to bring the College of Psychotherapists and Registered Mental Health Therapists to life.

There is great potential for improving the outcomes in Ontario by better leveraging the full diversity of expertise that's available in the province. We also believe that it's vital that the transitional council for the new college includes appropriate representation from currently unregulated professionals. It does not live up to the spirit

of the legislation if the body is composed predominantly of those who are already regulated by other colleges. For a mental health strategy to succeed, it's important to recognize that not all people want or need to receive care within the medical model. Our members make an essential contribution to the overall care mix of mental health services that are available in this province.

It's important that a choice of services be available in order to empower people with mental health problems. As you're well aware from the other presentations and some of the things we've said today, some of these people don't want to go for help. They're really nervous about going for help. For example, if you know someone and you can refer—someone you know is qualified and competent, but they may be outside of a model that's covered or recognized. So it's nice if people can have more choices. There's a need to recognize the role that families and other non-professional caregivers play in the lives of people with mental health problems and to promote well-being among family members and reduce the burden for caregivers. An integrated approach is needed to provide effective support for people with co-occurring mental and substance use disorders. In the transition from child to adult mental health services, youth often fall through the cracks as there is no specific system of care available for this age group.

We're noticing a huge difference now that students are getting younger and younger as they come to university in Ontario. Some of them come at 15 or 16, and it's shocking how well resourced and competent an adult they are. And others are, you know, teenagers. They're still very, very young, and they're trying to deal with all of the complications of living on their own—and life does interfere. When you're a university student or a college student, it's not just acne and bad hair days. We are a mental health clinic and it's very, very busy, and I think most people who are presenting here today will tell you that. The strain on the system at this point is enormous. I don't know exactly what the answer to that is. If you doubled our staff, would that help? I'm not sure. I think what really helps is when you find one organization, everyone benefits because then there are places for us to refer. We rely heavily on the Kingston community to refer students to when they're in real trouble. If they have to wait four to six weeks between sessions and they're dealing with something complicated and serious or they're chronically suicidal, that system won't work, so we need to find one that does. We have consummate, wonderful professionals in this town, and it is really nice to be able to access them, but we can always use more.

One final point: We're pleased to learn that the new amendments to the Psychotherapy Act, 2007, limit the use of the title "registered psychotherapist" to those who are licensed by the new college. This is a positive step in terms of promoting clarity to the public and enhancing public protection. I'm stunned at what clients think I am. They say, "Oh, I told my parents I went to see my doctor today," and I ask, "Did you mean me?" I'm not a doctor.

I have no medical training. I think this is really important. People really need to be educated about what we do, what information we have, and how we can help them, and how we can't as well. So I'm really thrilled to see this happen. Title protection helps the public understand that anyone holding themselves out to be a registered psychotherapist is regulated by the College of Psychotherapists and Registered Mental Health Therapists of Ontario. It's clear to the public that they're accessing care that adheres to a common standard of training and regulation. It's also clear that they can turn to the college for redress in the case of a complaint. We all like that. That keeps us all to a high standard, and that's why we entered this field. Nobody entered this field to do sub-standard work—well, hopefully; I certainly haven't met anybody in the thousands of health care providers whom I've met. They work harder than they have to. They work more hours than they get paid for. They are incredible people with amazing things to offer and they really care for the populations that they work with, but they can't do it all. So having a regulated body is really important.

It also gives them access to other resources, as I say. One of your clients is moving to another community and you don't know anybody there? It's really hard to just say to them, "Well, good luck. See you later." You have a place where you can find a list, you can find someone else to refer them to, and it's really important.

The creation of the new College of Psychotherapists and Registered Mental Health Therapists of Ontario offers Ontario a prime opportunity to enhance the quality and scope of mental health services in the province. CCA, in collaboration with the Ontario Coalition of Mental Health Professionals, looks forward to working with the Ontario government to bring the new college to life in a way that dramatically benefits Ontario's patients and clients.

I have lots of other things written down, but I would like to ask Barb for things that I've forgot, left out, mumbled over or said incorrectly.

The Chair (Mr. Kevin Daniel Flynn): Well, you've probably left time for one question at the end, so maybe we should go straight to the question. Anybody from the government? Sylvia?

Ms. Sylvia Jones: It's just a quick yes or no. Your association: Do you also cover pastoral care?

Ms. Barbara MacCallum: Yes. We have some of our members who are in that field, and we actually have a special interest chapter in the association for pastoral practice.

Ms. Sylvia Jones: Thank you.

The Chair (Mr. Kevin Daniel Flynn): France, anything? You're good? Everybody's good?

Thank you very much for coming today. It was a great presentation.

Ms. Robin Cameron: Well, that's very nice. I'm not sure if it's true.

The Chair (Mr. Kevin Daniel Flynn): You did a good job.

ONTARIO ASSOCIATION OF
CONSULTANTS, COUNSELLORS,
PSYCHOMETRISTS AND
PSYCHOTHERAPISTS

The Chair (Mr. Kevin Daniel Flynn): Our final presentation of the morning is the Ontario Association of Consultants, Counsellors, Psychometrists and Psychotherapists. Naseema Siddiqui is the president, and you're accompanied by somebody else, by the looks of it. If you'd just make yourselves comfortable. You have 20 minutes, like everybody else has had, and you can use that time any way you see fit. If you'd introduce yourself for Hansard before each of you speaks so we have a record. It's all yours.

Ms. Naseema Siddiqui: My name is Naseema Siddiqui and I'm the president of the Ontario Association of Consultants, Counsellors, Psychometrists and Psychotherapists. I said it in the right order so I keep my job; otherwise, I would be fired. They told me that. With me is the secretary of the board, Penny Kawasaki, and she will be doing the presentation, but I would just like to introduce.

Thank you, Mr. Chairman and members of the committee, for giving us this opportunity to present our views and those shared with us by our clients. I have over 30 years of experience working with the dually diagnosed developmentally delayed population, a population which is not even on the radar for mental health.

As the title would indicate, OACCPP is a professional organization of mental health service providers and we wanted to be as inclusive as possible. In 1978, OACCPP was formed as a lobby group to lobby for access to mental health services. Later on, as time developed, we became a full-fledged association, but we wanted to be inclusive, and that's the reason for the cumbersome title.

Improving mental health services and protection of the public are the goals of the government, and as professionals, we share those goals. In my mind, the protection of the public could be summed up in one word and that would be the end of our presentation, and that single word is "access." I'd like to elaborate a little bit on it: access to qualified, trained professionals; access to affordable, cost-effective services; access to diversity of services; and access to timely services.

1220

I think we have heard a lot about timely services, but I found it interesting that just two days ago I was driving—my destination was 10 minutes away—and I spent a full hour getting there because I was listening to Scott Chisholm, who's writing a book called *Collateral Damage*. I kept thinking, "This select committee has to hear this broadcast." He said, "A broken shoulder has no waiting list but clients with mental health issues" have to wait for their turn. This is so evident, especially in northern and rural areas. I worked in Smiths Falls and in Lanark county. There's only one psychiatrist for the entire county. I don't know what the current population is, but the last figure I had was 35,000 people.

Access to research which is applied, which is not sitting on a shelf, and access to qualified, trained professionals from multicultural communities: I went down Gerrard Street and looked at all the signs, and some I could read. I found it interesting that they have their own psychotherapists, they have their own lawyers, they have their own professionals; they don't know what is going on in the outside world. When I started to talk to them about the Psychotherapy Act, the psychotherapists or mental health service providers there did not know what was going on there, so we do need that, and we need involvement of all these groups.

Now I'm going to turn it over to my colleague Penny Kawasaki to present our views from OACCPP.

Ms. Penny Kawasaki: Thank you, Naseema, and thank you, Mr. Chairman and members of the committee.

Just a little bit of background about myself: I've worked in the field of mental health across the lifespan, for over 30 years as a psycho-educational consultant in the school system—elementary and secondary—and for the past 10 years, at the community college level in Ottawa at Algonquin College. I appreciate the—sorry, can you hear me?

The Chair (Mr. Kevin Daniel Flynn): Oh, yes.

Ms. Penny Kawasaki: Sorry, I thought it wasn't working.

I appreciate the opportunity to present the views of our association this afternoon.

First of all, I want to acknowledge two initiatives in this brief, the Mental Health Commission of Canada and Ontario's establishment of the Select Committee on Mental Health and Addictions, because we're now putting mental health, as a public policy concern, directly in the political spotlight. We're very encouraged by these initiatives, but I want to get into some of the barriers that we're facing that we feel very strongly about.

One of the barriers that's very daunting is the stigma, of course, of mental illness that plagues people both socially and in their family and in the workplace. Lack of funding for mental health and addictions treatments prohibits full and uncomplicated access to services; lack of access to a range of services with diverse approaches and methods of treatment that are fully accessible and affordable to all segments of the public; lack of access to services in a timely fashion—a few metaphors here: "A broken shoulder has no waiting list but clients with mental health issues have long waiting lists." Fragmentation of services and a lack of integrated best practices in dealing with the needs of individuals is a systemic problem. Multicultural competencies is a big one that we feel strongly about. Multicultural competencies and training available to minority groups and service providers must be acknowledged, as our demographic profiles are changing rapidly.

Investment in mental health services is not the only answer or solution to dealing with the mental health needs of Ontarians. We feel that strategies should include:

—timely access to mental health services, essential for safety and health promotion;

- system changes that are holistic in nature and commitment, where the focus is on best practices and individual client needs;

- collaboration with other professionals so that we can identify our strengths and limitations;

- commitment to develop a network of auxiliary professionals to whom its members will refer clients as required;

- accommodating regional disparity and not creating new accessibility challenges for health consumers, especially living in remote areas; and

- more studies are needed to reveal how many Ontarians remain undiagnosed or have mental illness needs that are unmet.

There's some statistical information that we've included in our brief which I'm not going to have time to go over. I want to leave some time at the end for questions.

As far as mental illness and social factors go, I want to start with the issue of poverty. Many anti-poverty initiatives recognize the link between poverty and mental illness, but efforts to reduce poverty as a social determinant of mental illness have been largely ineffective, and they need stronger efforts. For example, the Ontario disability support program is often geared to people with low incomes, but well over half of people receiving those benefits have a mental health disability, and there's never enough money to sustain their needs. I run into this all the time seeing clients.

Employment, the working wounded: According to award-winning author André Picard, public health reporter for the *Globe and Mail*, "Mental illness is costing the Canadian economy a staggering \$51 billion a year, and each day 500,000 people miss work because of psychiatric problems." Employers are not doing a lot about this. Picard adds, "Society's silence about mental health is deafening. When you are diagnosed, you disappear. Yet the vast majority of Canadians suffering from mental illness ... are not in the hospital but they're in the community and at work. Mental illness accounts for a stunning 40 per cent of disability claims and sick leaves in Canada."

I just want to refer a bit to Bill Wilkerson; he's the CEO of the Global Business and Economic Roundtable on Addiction and Mental Health. He said, "There's this attitude out there that if you come back from cancer, you're a hero, but if you come back from depression, you're damaged goods."

Multicultural competence and health services: We need a broader understanding of multicultural issues, such as ethnicity, religion, language and support systems, as all influence the health care consumers' ability to understand their conditions and comply with treatment protocols. These protocols should attempt to incorporate or complement traditional forms of healing; for example, the aboriginal populations. Having an expanded awareness of what actually constitutes multicultural awareness in best practice principles is fundamental to improving access. In this respect, there's very inadequate data avail-

able in Ontario about the experience of ethnic minority groups in relation to the mental health system.

We need more funding and research in the mental health needs of our multicultural communities. This is promoted a lot in professional associations, including ours, where we promote training and multicultural competencies at our PD workshops and conferences. Such training needs to be available on a broader basis to all mental health and addiction professionals. We also need to involve the multicultural communities as part of research teams dedicated to integrated health planning and design of services.

The mental health needs of Ontarians cross ministry lines, so there are many ministries often involved in care and treatment. Services should be accessed using a multi-modal and multidisciplinary model to make the whole process more seamless. We need access to a diverse range of mental health professionals. We need consistent and reliable funding to prevent gaps; there are so many people falling through the cracks, sometimes because there are so many different ministries involved, and the funding seems to vary from time to time. For example, the Roberts/Smart Centre in Ottawa doesn't have sustainable funding so they are now in crisis for offering service to their clients in the community.

We need affordable housing. It should be available for those with addiction and mental health issues.

I just want to talk a little bit across the lifespan and cultures and talk a bit about youth and children's mental health. Health promotion and prevention have become key priorities in health care, but there are still challenges. We need to recognize that health promotion services should incorporate a greater awareness of the challenges and social complexities facing our younger generation. There are so many things involved; for example, self-esteem issues with our young generation and so many complex issues there.

Seniors' mental health: While psychogeriatrics isn't a new field, novel approaches to seniors' mental health are reflecting a shift away from the medical model governing that field. Social determinants of seniors' mental health and a shift to wellness models are two such innovative approaches.

There's a whole lot with First Nations' mental health and Inuit and the high suicide rates. There are many hypothesized determinants, but all of us know that suicide and self-harm are events derivative of enduring hopelessness, a fundamental belief that the social world holds no viable options for a satisfying, productive life. In this respect, we believe that social advocacy must become part of every service provider's repertoire of interventions.

1230

I think Naseema has mentioned some specific groups like the developmentally disabled population. When Rideau Regional was closed in Smiths Falls, all the people were put into the community, but this is a very genuine population that needs to be continually and increasingly recognized, because they need improved

access to mental health services in the community now that that facility has closed.

In Canada, few cultures are socially isolated. Social migration, technology and access to a global world through various media, including the Internet, all interact to influence the multifaceted world of the Inuit, First Nations or Metis client. Keeping this principle in mind, we feel that multifaceted professional consultation and collaboration is absolutely essential to delivering best practices to multicultural populations, especially in remote areas.

A spectrum of service settings should be available depending on the individual needs.

Prevention strategies should be in place to identify and treat early onset of problems so that these problems don't become more serious down the road.

There are lots of gaps and barriers: long waiting lists, as we know, to see certain types of service providers, like psychiatrists working with adults; funding barriers in hospitals in schools; and community agencies that have huge backlogs and waiting lists and that can't hire more professionals to provide those services. Also, there are parallel service providers that are available.

We need more outreach in cities and remote areas.

Evidence-based research should be done on all service initiatives to hold funding agencies accountable.

We need primary care teams of professionals working in the community, using a model of collaboration and co-operation among and between diverse professionals offering services.

So, in conclusion, we hope that the Select Committee on Mental Health and Addictions will review the funding for mental health, which is inclusive of all sectors mentioned in our brief. We hope that through your work you will explore systems change and make recommendations to improve access, as Naseema was saying, to services for the diverse populations in this province. We'd be very happy to collaborate further with you.

We will take questions. Thank you very much for this opportunity.

The Chair (Mr. Kevin Daniel Flynn): Very good; thank you very much for your presentation. Any questions from the government side? Helena?

Ms. Helena Jaczek: Yes, thank you very much. You've brought up a number of issues that we've been hearing as we travel across southern Ontario.

I was wondering if you've had any experience with peer navigators as it relates to mental health counselling and if you see that as a useful adjunct, any experience that you've had in that regard.

Ms. Penny Kawasaki: Peers?

Ms. Helena Jaczek: Yes.

Ms. Penny Kawasaki: I'll tell you my experience at Algonquin, at the college. We use peer support people in the counselling department. Sometimes that helps them come in and self-refer, because we don't go banging on doors. Students have to come to us, so we have to depend on their self-advocacy skills, which sometimes are

greatly lacking. So we feel that's important, but it isn't used enough.

We try to stress that when we work with high schools, to get the students, when they're talking about transition points and developing their career paths, to generate, through peers, this kind of advocacy, to make it a more seamless thing and to not feel as if they are kind of out there floating around.

Ms. Helena Jaczek: Thank you.

Ms. Penny Kawasaki: That's a good point.

The Chair (Mr. Kevin Daniel Flynn): Thank you. Sylvia?

Ms. Sylvia Jones: Very briefly, you talk about the integrated system on page 10. There have been a number of presentations where we have been encouraged to have a lead ministry, a lead agency. Have you any thoughts on that, and if you do, do you have a preference on which ministry would be that lead, or in fact a separate ministry?

Ms. Penny Kawasaki: I don't know. I think some ideas in the past have been tossed out, like the Ministry of Children—because right now, it's so mixed up. Depending on the need, you're crossing boundaries and then you're facing systemic barriers because of the limitations of the ministry, which may not all be on the same page. It would be nice if everything were integrated like that. I don't know at this point which ministry would—

Ms. Naseema Siddiqui: I'd like to take that question. First of all, before I forget, I did not introduce myself as the chair of the Ontario Coalition of Mental Health Professionals because today, I was representing OACCPP. Like CCA, OACCPP is also a member of the coalition. Having said that, I think if we are talking about our mental health, it's all health; it's all part of the same person. I don't think that we should be separating. We feel that Health is the lead ministry, but collaboration or integration with other systems is absolutely essential. I see that in the field of dual diagnosis where just two ministries are involved. This is based on my experience, 30 years of working in the field: When the communication is not there, we find just with the two ministries, the services fall apart.

The Chair (Mr. Kevin Daniel Flynn): Thank you. France, the final question of the day.

M^{me} France Gélinas: Just a quick one: I appreciate the emphasis you've put on diversity. I realize that working in Ontario, a number of your members would work in French-language-designated areas of the province under the French Language Services Act, so my question is, do you keep track of which of your members can provide services in French, and second, are there best practices out there for providing mental health services to the minority francophone population?

Ms. Naseema Siddiqui: We do keep some track, but unfortunately I don't have those numbers. We would be able to provide you with them if you are interested in those numbers.

As far as best practices are concerned, I'm not even sure if we fully understand what best practices are, because I looked at the definition, and in every different group I went to, the definition was very different. I know what I understood to be best practices, and that is a client-centred system. The services there are integrated when it is a client-centred system. But when I look at the definitions—I did some research on it a few years ago and then again before this committee, so I'm not sure what we understand by "best practices." It depends on the interpretation of the individual province, the individual region and the individual practice.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today. Your presentation was appreciated.

Ms. Naseema Siddiqui: Thank you very much. Thanks for the opportunity.

The Chair (Mr. Kevin Daniel Flynn): That is the end of our meeting for the day. Sylvia and France are off to the airport immediately. The rest of us are going to meet in the Frontenac room just beyond the hotel reception desk for lunch. Our bus will be here at 1:30. Stewart Stein from the Ontario Telemedicine Network put his PowerPoint presentation from this morning on the memory sticks that you've been presented with.

Thank you to those members of the public who attended this morning and stuck out the whole morning with us. We're adjourned.

The committee adjourned at 1238.

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MH-14

MH-14

ISSN 1918-9613

**Legislative Assembly
of Ontario**

First Session, 39th Parliament

**Assemblée législative
de l'Ontario**

Première session, 39^e législature

**Official Report
of Debates
(Hansard)**

Tuesday 8 September 2009

**Journal
des débats
(Hansard)**

Mardi 8 septembre 2009



**Select Committee on
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Telephone 416-325-7400; fax 416-325-7430
Published by the Legislative Assembly of Ontario



Service du Journal des débats et d'interprétation
Salle 500, aile ouest, Édifice du Parlement
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Téléphone, 416-325-7400; télécopieur, 416-325-7430
Publié par l'Assemblée législative de l'Ontario

LEGISLATIVE ASSEMBLY OF ONTARIO

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SELECT COMMITTEE ON
MENTAL HEALTH AND ADDICTIONSCOMITÉ SPÉCIAL DE LA SANTÉ
MENTALE ET DES DÉPENDANCES

Tuesday 8 September 2009

Mardi 8 septembre 2009

The committee met at 0906 in committee room 1.

SUBCOMMITTEE REPORTS

The Chair (Mr. Kevin Daniel Flynn): Okay, we can call to order. Welcome back, everybody.

We've got two orders of business to deal with before we start hearing from our delegations today. The first is a report of the subcommittee that was dated June 30 and one that's dated August 11 and August 19. Do they need to be read into the record? Would somebody like to read them into the record? Liz?

Mrs. Liz Sandals: So I am told.

The Chair (Mr. Kevin Daniel Flynn): Yes.

Mrs. Liz Sandals: I move the adoption of the subcommittee report that is dated Tuesday, June 30, 2009.

The subcommittee met to consider how to proceed with site visits to First Nations communities and recommends the following:

(1) That the committee clerk find contacts in each community so that the select committee will have a local tour guide.

(2) That legislative research prepare a memorandum detailing what legislative research has done to date and what they are working on.

(3) That legislative research prepare a bare-bones summary of the committee's work to date. This summary is to be presented by the Chair of the select committee at the Minister of Health's advisory group on mental health and addictions summit July 13 to 14, 2009.

(4) That the select committee visit various First Nations communities in the south in the fall, including Mohawks of the Bay of Quinte, Oneida Nation of the Thames and Six Nations of the Grand River.

(5) That the committee clerk, in consultation with the Chair, be authorized, prior to the passage of the report of the subcommittee, to commence making any preliminary arrangements necessary to facilitate the committee's proceedings.

The Chair (Mr. Kevin Daniel Flynn): Thank you. Any comments on that? Water under the bridge.

All those in favour? Opposed? That's carried.

We have another one. Liz, are you doing that as well?

Mrs. Liz Sandals: Subsequently, I move the adoption of the summary of the subcommittee business conducted on Tuesday, August 11, and Wednesday, August 19.

The subcommittee met to consider how to proceed with site visits to First Nations communities and with public hearings in Toronto, Thunder Bay, North Bay, Sudbury and Ottawa, and recommends the following:

(1) That the committee travel to the First Nations of Wabaseemoong, Pikangikum, Sandy Lake, and possibly Attawapiskat and Kashechewan.

(2) That the committee meet with officials of law enforcement in Sioux Lookout.

(3) That the committee start its second round of public hearings in Toronto on September 8, 2009, followed by Ottawa on September 9, Sudbury on September 10 and Thunder Bay on September 11.

(4) That groups and individuals be offered 15 minutes for their presentations, including time for questions, in Toronto and Ottawa.

(5) That groups and individuals be offered 20 minutes for their presentations, including time for questions, in Sudbury and Thunder Bay.

(6) That the North Bay area groups that requested to appear be scheduled by conference call during the Sudbury hearings.

(7) That during the fall hearings in Toronto, groups and individuals be offered 15 minutes for their presentations, including time for questions, and that the committee meet on Wednesdays from 4 p.m. to 6 p.m. when the House is sitting.

(8) That OPSEU be offered a presentation time in Ottawa.

(9) That the Ontario Human Rights Commission be offered a presentation time in Toronto.

(10) That the committee clerk, in consultation with the Chair, be authorized, prior to the passage of the report of the subcommittee, to commence making any preliminary arrangements necessary to facilitate the committee's proceedings.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Liz. All those in favour? Those opposed? That is also carried.

Ms. Sylvia Jones: Chair, one question—it ties back to the First Nations community visits in the fall. Do we have a date on that?

The Chair (Mr. Kevin Daniel Flynn): No. We should establish one.

Ms. Sylvia Jones: Yes.

The Chair (Mr. Kevin Daniel Flynn): And we learned a lot from the last round.

Mrs. Liz Sandals: There are only a couple of constituency weeks, and there's a limit to how long you can hold those days. I'm getting all kinds of requests for things I need to do in those weeks.

The Chair (Mr. Kevin Daniel Flynn): If the subcommittee wants to meet over lunch today, or over lunch any time or during some free time this week, I'm sure we can establish a date pretty quickly.

Mrs. Liz Sandals: That would be really helpful.

MENTAL HEALTH
AND ADDICTIONS STRATEGY
CANADIAN PENSIONERS
CONCERNED-ONTARIO

The Chair (Mr. Kevin Daniel Flynn): Let's get started, then. We have our first group here who's with us. It's Barbara Kilbourn and Christine Mounstevan. If you'd like to come forward; make yourself comfortable. There's some water there, if you need some. They're our first delegation of the day; that's probably why there's nobody in the audience yet.

As you've just heard, we've allowed 15 minutes for your delegation, and if you would leave a little bit of time at the end for some questions, that usually works out well. Having said that, the floor is all yours.

Ms. Barbara Kilbourn: My name is Barbara Kilbourn. I'm the current president of Canadian Pensioners Concerned. We're an organization founded in 1969—so it's our 40th year this year. It's a provincial and national, voluntary, membership-based, non-partisan organization of mature Canadians committed to preserving and enhancing a humanitarian vision of life for all citizens of all ages.

We would like to applaud the Ontario government, the Minister of Health and Long-Term Care and his advisory group for the development of a framework for a proposed 10-year mental health and addictions strategy for the province. This initiative reinforces the work of the Mental Health Commission of Canada and its work in developing a national strategy for Canadians' mental health, mental illness, recovery and well-being. We are supportive of the seven proposed directions and are especially supportive of the emphasis on person-directed services within an improved, transformed system. Now I'm going to turn it over to Christine.

Ms. Christine Mounstevan: I would like to start at the last page first: "Of the seven directions proposed, which do you think is the most important and why?" A 10-year strategy is ambitious in its intent and implementation. Transforming the system is the most important. What exists today in 2009 is inadequate. It's a patchwork of programs and priorities held together by ministry policy making mental health and addictions a central focus.

The first accountability is to increase the mental health budget significantly. Then, as the 10-year strategy is implemented, key performance indicators can be measured:

the existence and/or availability of community mental health and addiction services, wait times for services, how people use the services available as well as new or improved collaboration among service providers. But the public needs to know that Ontario is pledging to increase mental health spending significantly, and we believe that a goal of 10% in 10 years or less should be reached. The public also needs to know what percentage of mental health spending will be allocated to the needs of a growing, aging population.

Canadian Pensioners Concerned-Ontario would like to encourage the province to adopt, in all relevant ministries, the use of the Seniors' Mental Health Policy Lens Toolkit. It was developed in British Columbia in 2005 and has been evaluated at 15 sites across sectors throughout Canada. Its use would reinforce the mental health and addictions strategy to create healthy communities. The tool kit is intended to facilitate social environments, including health services, that promote and support the mental health of older adults, reducing the likelihood of mental health problems occurring.

What is most important about the tool kit is its inclusion of seniors' values, priorities and perspectives, highlighting seniors' strengths.

There is a shortage of geriatric specialists in Ontario. Positions in medical schools are not filled. The supply-demand difficulties of geriatric, psychogeriatric and neurobiological specialists must be addressed with the Ontario Medical Association and the Ministry of Health and Long-Term Care, specifically physicians' training and pay structures.

Family physicians are in demand throughout the province, especially in the north. In integrating mental health and addiction services with other health and social services, family health teams should have additional training and resources to help in the development of local mental health services or finding and expanding local services. Family health teams should not be penalized if patients are referred to family physicians outside the team who have psychiatric and mental health expertise.

Ageism related to housing or mental health or addiction issues exists and should be addressed as contributing to the stigma, the power imbalances or unavailable culturally competent services. Many older adults believe the prejudices and stigma related to their mental health issues are inevitable and they may not or do not seek help. Public attention and education for professionals and the general population are needed to reduce and eventually eliminate these beliefs.

Act early: Dementia and depression are seen as inevitable for older adults, but are not necessarily a normal part of aging. The strategy must differentiate between and provide for those who develop dementia and depression later in life and those who have struggled with mental health and/or addiction issues throughout their lives. In fact, dementia appears to be a normal physiological part of brain aging which drugs are so far able only to slow to some extent. The distinction must be made between dementia and depression which, late in life

and biologically based, is triggered by such issues as loss, chronic disease and isolation. The belief is that age-onset depression could be prevented or its symptoms mitigated by screening, early intervention, or appropriate treatment where necessary, including medication and/or taking therapy and/or social support. Also, the strategy notes state that 10% to 25% of seniors experience mental health disorders such as depression that are usually related to medical illness, disability, and social or emotional isolation. Coping with loss—of a loved one, of income security, of a home setting—can also trigger depression, the need for medical intervention or other health care professionals, or peer support or community services.

CPC strongly supports the important role of peer-based programs, not only in early identification but also in continuing community and social support networks, whether a senior is awaiting treatment, in a treatment program, or coping with a day-to-day mental health issue. CPC's new speakers' program continues the work of the Older Persons' Mental Health and Addictions Network, OPMHAN, and sends those with lived experience to raise awareness of those at risk of or dealing with depression. It is a prime example of a prevention program that is effective and cost-efficient.

The population of older persons with depression experiences a suicide rate which is five times higher than that of any other age group. Of all age groups in Canada, men over the age of 85 have the highest rate of completed suicides, yet very little attention is paid to addressing this. An indicator of improved services for older adults will be the suicide rate, especially that of men, and will be measurable and help the province and each LHIN in their accountability for community and health services. Thank you.

Ms. Barbara Kilbourn: Those are our comments.

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The Chair (Mr. Kevin Daniel Flynn): That's wonderful. You've left all sorts of time for questions. You've used up about eight and a half minutes. We've got about six and a half minutes, so maybe two minutes for each party. Christine or Sylvia, would you like to start it off?

Mrs. Christine Elliott: I just had a question regarding the last comment that you made regarding the suicide rates. Who keeps those statistics?

Ms. Barbara Kilbourn: I think it's the mental health association.

Mrs. Christine Elliott: You hear about it more in the context of very young people, so I wasn't aware of that. That certainly will be a measure of success, to reduce those significantly.

Ms. Barbara Kilbourn: It's one of the shockers.

Ms. Christine Mounsteven: I think that's where we begin to look at statistics. Often, things are not measured in terms of the older person; it's just the general population. When you begin to look at younger and also older, you see where the marked difference is with the general population.

Mrs. Christine Elliott: Thank you.

The Chair (Mr. Kevin Daniel Flynn): France?

M^{me} France Gélinas: I was also surprised to hear about men over 85. It's the first time I've heard these stats, and I'm certainly glad you brought it to our attention.

My question has to do with the peer support program, the new speakers' program that continues the work of the Older Persons' Mental Health and Addictions Network. I'm not familiar with this. Could you tell me how it works?

Ms. Barbara Kilbourn: Basically, it's a speakers' project. We're going to be training people who have either an interest in or a personal lived experience with depression, specifically. We have \$13,000 to do two places. It's money that was left from the Older Persons' Mental Health and Addictions Network, which has had to fold for lack of continuing funding. We're going to be starting in the Kawartha Lakes area and Toronto. There are about four speakers trained from the past. We'll be adding to that and then hoping to have materials reprinted if we can find some fairy godmothers who will give us materials, because there are some really good materials that the Older Persons' Mental Health and Addictions Network put together. So it could be used to raise awareness in the seniors population.

M^{me} France Gélinas: But it wouldn't lead, necessarily, to them supporting a self-help group. It would be a one-off—

Ms. Barbara Kilbourn: It could, because locally, if you're going to raise awareness and you have people isolated, and they get to their family doctor and the family doctor wants resources that perhaps the local Canadian Mental Health Association branch could help with, and continue to get a peer support group going—they're very inexpensive to run. I personally was with an organization for women that saw the success of peer support—magical; people were still in touch 11 years later.

M^{me} France Gélinas: So you're training speakers with the—

Ms. Barbara Kilbourn: To raise awareness only, and then what the community can do with that is up to the community, because we don't have any resources.

M^{me} France Gélinas: And with your \$13,000, how many people do you hope to train as speakers?

Ms. Barbara Kilbourn: We figure we'll do six to eight. Basically, if they are located either in Kawartha Lakes or Toronto, they'll cover their own travel, and we won't have to rent space because we'll be at the invitation of current groups.

The Chair (Mr. Kevin Daniel Flynn): Thank you.

Any questions from the government? Liz?

Mrs. Liz Sandals: Yes. You mentioned the issue of geriatric dementia. Certainly, that's a huge issue both for families and in long-term-care homes. I'm wondering if you've got any programs that you particularly recommend as being effective in dealing with geriatric dementia. What sort of programming have you seen that you would tell us about and recommend to us?

Ms. Barbara Kilbourn: It's not really our field of expertise. We're broader-based; we wouldn't specifically know of those. Both Christine and I have about 35 or 40 years of experience in and around mental health. I was in the corporate and private sector as a volunteer and then went into paid work in and around mental health issues,

Ms. Christine Mounsteven: I was, for 30 years, a mental health and addictions counsellor. I can tell you that in working with the population who are chronically mentally ill and also have addiction issues, at age 65 they had to move on from the program that I was managing. So what happens is we have a population of people who have grown up with mental illness who are now aging, and they're attempting to get into the system as an older person and there's very little that is available for them.

The other difficulty that we experience in what you see is that people begin to self-medicate. That self-medicating, of course, brings all sorts of other issues up. What is happening within the community as it is now is that if someone is self-medicating or is seen as an addict or abusing, it is often said that they have to stop using before they get into services. That's defeating of anything because the person needs help.

The only other thing I can say to you is that when we put in this about geriatricians, we know that there are very few geriatrics specialists who are graduating, and part of that is because of the way things are funded. We have people who get to a certain place, they're looking at specialties, and because of the cost of education today they do not go into geriatric medicine; they're going into internal medicine. The reason for that is that when you go to your doctor, the doctor has so many minutes to care for you. An older person needs more than 10 minutes, and that doctor does not get paid for the additional time that they take. So someone who has a practice of seeing—I don't know how many people doctors see today, but if they have a practice that's seeing 30 people in a day, we'll say, if you're seeing an older person you could cut that by half. Therefore, they're not going to get the funding.

Mrs. Liz Sandals: You said—

The Chair (Mr. Kevin Daniel Flynn): I'm afraid we're out of time, Liz, unfortunately. Sorry.

Thank you for attending today. Your presentation was appreciated.

CATHY DANDY

The Chair (Mr. Kevin Daniel Flynn): Our next speaker today is Cathy Dandy. If you'd like to come forward, Cathy. Just make yourself comfortable. The same rules apply. You've got 15 minutes to use any way you see fit. If you could leave some time at the end for some questions, that always works better, it seems. If you're comfortable, the floor is all yours.

Ms. Cathy Dandy: Thank you. Good morning. I feel like I've been here a few times—not to this committee, obviously, but to others. As you know, my name is Cathy Dandy. My background is, for years I was a parent

activist. I was with the group People for Education, then I moved on to the Toronto Parent Network. I then was elected to the Toronto District School Board as trustee for Toronto-Danforth and—because that is not paid at a full-time salary, and I have three children—I also have a full-time job in the children's mental health sector. I work for a very large children's mental health agency and I've been there for the past three and a half years. That is not my background and I have learned an enormous amount while being there about mental health. I'm going to talk briefly about some of that work and some of the work I did while I was an activist and as a trustee, and then I'm going to just talk a little bit more personally.

I have spent the last three or four years researching the concept of integrated service delivery or hubs. I have given you a document that summarizes some of that research. I'm not going to review the statistics on children and youth mental health because I'm sure you're familiar with them—you're familiar with the outrageous rate of suicide, that anxiety and depression are huge issues for many children and youth in our schools, and also that 75% of mental illnesses begin between the ages of 12 and 25—but I am going to talk about the fact that much of the research around integration or hubs leads us to know that if we coordinate our efforts, whether through education, mental health or physical health, it leads to better outcomes.

In 1990, the Ontario Ministry of Community and Social Services said, "There must be a single major physical centre that operates as a hub of services for children within each community." So I'm talking about what we need to do to deliver properly to children and youth. "Where possible, the school should be this centre for service provision." What we know from studies out of the United States is that improved grade scores, improvements in personal or family situations, a reduced dropout rate, reduced behavioural and discipline problems, and a decrease in self-destructive behaviours, including irresponsible sexual activity and drug use, are all the result of coordinated activities.

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The 1983 Ontario Child Health Study shows that when we centred emotional and behavioural treatments in places where children and youth are, they showed a decrease in problem behaviours such as anxiety, depression and opposition, and an increase in positive behaviours such as self-control and co-operativeness. Families improved. Parents had a much better ability to cope because services were centred in those areas. The Highfield project also demonstrated that. The Highfield project is still going on, but people seem to pay little attention to it.

SchoolPlus in Saskatchewan also has moved into the area of coordinating, at the most senior level, policies and funding in order to integrate services in schools and around schools.

There are excellent attempts in Ontario to do this, but it is not supported by government. The Bluewater District School Board and the Halton Our Kids Network have done some remarkable things. But these excellent

attempts to promote learning and support students' complex needs are hampered because of silo-based funding and different definitions of outcomes. I think that's where we need to go. We need to think about what an outcome looks like.

Just briefly, I have had two personal experiences. One was, I was assaulted by someone who was mentally ill. She was already charged with another assault. My assault was dismissed because the crown attorney said they had to bargain in order to convict on the first, and the bargain was to let my assault charge go. So it was never followed through. My children witnessed that assault, and I had to tell them that nothing happened. The reason nothing happened was, as I was told by the crown attorney, that the court system can only deal with the most extreme cases and mandate mental health treatment. Once a person reaches adulthood, if they have not acknowledged or are unwilling to acknowledge a mental health problem, there is really little that can be done. The scatter fire that occurs from someone who is an adult living with mental illness among family, friends and community can be shocking.

My brother-in-law also experienced and is continuing to experience a bout of serious mental illness, leading to verbal abuse and the destruction of his marriage. He now too lives alone in the community and is barely receiving any treatment, partially because he lives in a community where there is little treatment available and partially because he is terrified and does not want to acknowledge that he has a mental illness.

I will repeat it: Once people reach adulthood and they have not received any intervention, there is a huge likelihood that they will cause untold damage in their families and in the community.

That leads us to children and youth. It makes so much sense to implant these services and to look at what we really define as outcomes in our community schools. I realize that the Ministry of Education has undertaken some initiatives such as the student support leadership initiative, but that does not even begin to get at the problem.

The most personal story is my daughter's. Last year, she started grade 9 at a high school in Toronto. Despite much talk at home, because her brother had struggled, we found her getting deeply involved in drugs, which culminated in May with her cutting herself. We have gone through a very difficult cycle. She has come out the other side. She was away at camp for a month and I think she realized a lot of things about herself. But in that process, what I found out was that that high school is just rife with girls cutting themselves. It has become the anorexia of the 2000s. Are there any resources there? Is there any way to get at those children? No. It's not my school, but as a trustee, I was able to ask for help, and we did get a social worker in. But we have school social workers who are working with seven schools each, our guidance counsellors are counselling on college and university, and our child and youth workers are barely on the ground. They were ripped from our schools and they were not really returned.

What I know as a trustee is that we have lots of space in our schools. That space is being touted as a liability, that we have declining enrolment. That space is an opportunity. Public institutions could be in those buildings, such as child and youth mental health agencies. They could reside in that space. They could own that space and they could operate in that space. I've talked to many EDs across the city, and they think it would be a fabulous idea. We can move to that, and there are efforts to move to that. As I said, the Our Kids Network has worked to do that. The Toronto District School Board is on the edge of creating a task force to look at how we can repurpose some of our school space. But one of the biggest obstacles to this is outcomes.

In education, an at-risk student is someone who fails to accumulate credits. In mental health, an at-risk person is someone whose life is falling apart. The reality is that unless we look at how we define an outcome—what do we want for our children and youth? Do we want them to lead healthy, emotionally successful lives, physically successful lives? We know so much about teaching pedagogy that we can teach. Teaching can be done. Our teachers are being trained in incredible ways now. We have a wonderful mentorship program, and the province has supported that. But until the government moves to support local initiatives to coordinate services on the ground, it will be disastrous for children and youth. We do not have even close to the resources, and even if those resources were—it is about coordination; it is also about funding, because children's mental health has not received even close to the amount of funding that's needed, even just to maintain services.

The government has a huge role to play in this. It is not enough to just look at how we can collaborate better. It is not enough to say—and this is what I have heard from government—"We can just go away and do it; there's nothing stopping us." There is lots stopping us. There's a funding formula that defines school space in a certain way. Nobody is mandating that children's mental health agencies move into these buildings and deliver service directly to these children and youth. Nobody is examining what exactly is happening to children and youth in our schools and what is causing their credit accumulation to not exist. It's because they are either hungry or ill or they're mentally ill. Once we support that, they will learn. We don't need to have more student success strategies around how we support their learning. We need to support their well-being. That is the outcome we should be looking for, and that is why we need coordinated policies at the most senior level and co-ordinated funding; we need cabinet-level coordination.

That is what goes on in other jurisdictions, and that is why I've provided you with my research and with some examples of it. Great Britain is moving, under Every Child Matters, to do exactly this. Why is it that this government cannot move to do senior-level coordination? This would not just benefit children, youth and families; this would benefit seniors. We have obviously—you heard from the last speaker—a huge problem with

seniors' mental health. We could centre these things in hubs. We could deliver in an efficient way, in buildings we already have, with services we already have, if they were coordinated and funded in a much more holistic manner.

The community is already doing its part. At the mental health agency I work for, we have instigated a peer navigator pilot project. We're going to be looking at working to support parents and families and children and youth in understanding how the system works and how to navigate it, how to navigate the interface between the mental health system and the education system. As I said, the Our Kids Network and the Bluewater board are doing their part. The Toronto District School Board is now moving to do its part. But we are hampered by poorly written and poorly coordinated policy, lack of funding and lack of coordinated funding. Although I've heard over and over again from people within government that it's really difficult, I would say that that is a poor excuse for allowing children in a high school to slash themselves.

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I have to insist that while it may appear difficult at the start, many, many jurisdictions have moved to do this and are doing it successfully. There are some excellent examples in the United States as well. There is a fabulous website—there are many of them, and one of them is around educational facilities and rebuilding them and renovating them expressly for the purpose of delivering to the whole community.

So I urge you to review what I've given you. I urge you to consider that this is not just about mental health but it is something that could capture all ministries that deal with children and youth within government. Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Cathy. We've got time for probably only one very brief question, starting with France and probably ending with France.

M^{me} France Gélinas: One very brief one. There is lots to think about. Were you involved in developing the hubs, in your role as trustee, in the schools under your school board?

Ms. Cathy Dandy: I am involved in it now. We're looking at how we can do that more effectively and how we can take advantage of many of the community partnerships that already exist, many of the community tables—the First Duty Network, which is not about mental health but is an excellent example of how community and government came together and wrote up a model with very clear guidelines around alternative delivery of services in schools and coordination of services. We'll certainly be looking at that.

I think we're going to be moving to designating a fairly senior person within the board to coordinate that and to look at the various funding.

M^{me} France Gélinas: My question was, were you able to secure any funding to develop your hubs?

Ms. Cathy Dandy: Oh, No, not yet. We will be looking to do that. I know there are small pockets of

funding around the Ministry of Children and Youth Services, and we will be looking to do that.

Actually, I'm glad you've raised that. I think one of the biggest problems around funding is that we've moved to a project-based model, similar to what you would find with grants and foundations. That doesn't work. I mean, I'm sure we could secure some temporary project-based funding, but what we need is sustainable funding.

In Saskatchewan, the funding model will be co-ordinated from various ministries. Then people are hired on the ground to then coordinate it on the ground. That is sustained funding; that is not project-based funding. People are needed, and that's where the funding needs to go.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Cathy, for coming today.

FAIR SHARE TASK FORCE

The Chair (Mr. Kevin Daniel Flynn): Our next delegation this morning is from the Fair Share Task Force. John and Sandy, if you'd like to come forward and make yourselves comfortable. You have 15 minutes. You can use that in any way you see fit. If you would leave some time at the end for questions and answers, that works. The floor is all yours.

Ms. Sandy Milakovic: Mr. Chairman and members of the committee, I'm Sandy Milakovic, the CEO of the Canadian Mental Health Association, Peel branch. I am joined by John Huether, volunteer chair of the Fair Share Task Force. As representatives of the Fair Share Task Force, we thank you for this opportunity to speak to you.

Our presentation will be complemented by a more comprehensive written submission later this fall. It's being developed through a collaborative effort by the majority of the key mental health and addiction service providers and their partners in housing, justice, social and community services in Peel.

The Fair Share Task Force is a community coalition of social and health agency leaders and volunteers who are committed to advocating for equitable access to social and health services through funding equity across the province.

We are encouraged by the recent increased attention to mental health and addictions by the Legislature, by the Ministry of Health and Long-Term Care and by the Ministry of Children and Youth Services. We trust that this attention will result in specific action to combat the stigma associated with mental health and addictions, and increased accessibility to services and supports for all Ontarians.

Peel region is the second-largest regional municipality in Ontario, with over 10% of the population. As it has done since 1980, Peel continues to grow by about 30,000 people per year. Fifty per cent of Peel's population are immigrants and 50% are members of visible minorities. The Peel child poverty rate has grown at the rate of 1% per year since 2001, to a current estimate of 79,000 children. There is also an emerging geriatric population

and a growing level of youth violence. The need for mental health and addiction services is great, as demonstrated in our presentation of accepted prevalence rates applied to Peel region. So the availability of accessible mental health and addiction services is extremely important in ensuring that Peel is a healthy and safe community.

We recommend, as the previous speaker did, that the ministries responsible for mental health and addiction services mandate in legislation the provision of a full range of services, from prevention and early intervention to intensive interventions and ongoing community supports, that should be available to any Ontario resident in need of them. We also recommend that these ministries measure and monitor the access to these services for all Ontarians. The establishment of appropriate wait list targets for community-based and inpatient mental health and addiction services, similar to those in place for cancer treatments and knee surgeries, may provide a useful focus to create system improvement.

Our community benefits from the contributions of many immigrants with a broad mixture of culture and races. We understand the importance for service organizations of learning how to communicate with people from all cultures. Services that are sensitive to different cultures and provided in the appropriate language are especially crucial in the fields of mental health and addictions.

Research demonstrates the risks of failing to address mental health disorders, including psychosis, anxiety and depression, and addictions, among new and second-generation immigrants. We read the tragic consequences of this failure in the press. There is also considerable evidence that racial discrimination has a negative impact upon the mental health of individuals.

We would urge your committee to give full consideration to the work of the Honourable Alvin Curling and the Honourable Mr. Justice Roy McMurtry in their year-long study on the roots of youth violence. They provide substantial documentation about the relationships between youth violence, racism, poverty and mental health. This latter connection was so strong, and the lack of accessible, community-based mental health services so stark, that they recommended that the province invest an additional \$200 million for accessible community mental health and addiction services for children, youth and their families.

We view the implementation of an effective, accessible and comprehensive mental health and addiction strategy as an important component to support the province's praiseworthy commitment to reduce child poverty. We note that investment in affordable supportive housing is a significant source of support for persons suffering from addictions or who have mental health conditions, and a key factor in the prevention of recurrences.

The neighbourhood-strengthening strategies in the *Breaking the Cycle* report and in the *Roots of Youth Violence* will also be effective in supporting persons facing the challenges of mental illness and addictions. Peel's unique Families First project demonstrated the

value of developing partnerships to help social assistance clients address their mental health and addiction challenges.

Mr. John Huether: Funding policy must also be a fundamental component of an effective strategy for mental health and addictions in Ontario. Funding inequity is at the root of inaccessible services, long wait times, and low levels of utilization of local services in Peel and in other growth areas. We therefore support the commitment of the Ministry of Health and Long-Term Care to the implementation of a population- and needs-based formula for fund allocation to the LHINs, and urge its timely application.

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We recommend that the Ministry of Children and Youth Services and the Ministry of Community and Social Services also adopt a needs- and population-based approach to funding their services. The government also needs to redress the historical funding inequities for social and health services through a phased-in set of investments in order that high-growth areas are able to meet the needs of their residents.

As part of our handout, we have provided you with some documentation of the current funding inequities for your information: For Peel, the per capita funding for children's services is \$130.60, compared to the per capita provincial average of \$240.10 in 2007-08. The picture is \$10 worse for York region. In Peel, there are now over 360,000 children and youth between the ages of 0 and 19. The difference in per capita funding represents a gap of \$39 million if Peel were to be funded at the level of the provincial average per capita. This gap has been growing for Peel and the 905 GTA since 1990. It is not acceptable.

There are similar disparities between the provincial per capita funding levels for mental health and addiction services funded by the Ministry of Health and Long-Term Care. Peel is served by two LHINs: the Mississauga Halton LHIN and the Central West LHIN. For community mental health services, the per capita funding for the province is \$52 per resident; for the Central West LHIN it is \$36; and for the Mississauga Halton LHIN the per capita funding is \$21—the lowest in the province, and less than half the provincial average. For addiction services, the per resident funding for the Central West LHIN is \$2, the lowest in the province, while the funding for the Mississauga Halton LHIN is \$4, compared to the provincial average of \$13.

These funding inequities result in very limited access to service and deny many Peel residents the ability to obtain assistance for mental illnesses and/or addictions in a timely fashion within their local communities. The service providers behind every door within the Peel community and other growing communities are not and will not be able to be the right door for those in need of their services unless they are provided with funding support for the services that are appropriate to the populations they serve.

We would like to conclude our presentation by providing you with a series of examples of the consequences of this funding situation.

The 38,000 residents in Malton and 56,000 residents in Caledon do not have any local access to any community mental health services.

Parents seeking help for their child who is a victim of bullying or any other serious condition have to wait six to eight to 12 months for services for counselling.

When the police encounter a youth who is beginning to be involved in gang or criminal activity and who is clearly in need of mental health intervention, they cannot access services for him within a reasonable time.

A recently unemployed father of three who has a drinking problem cannot obtain support to help him deal with his addiction, and his family continues to suffer as a result.

An immigrant family having difficulty coping with their teenaged children who want to test their limits and cultural expectations is unable to obtain culturally competent support in a timely fashion.

The South Asian grandparent who is asked to look after her grandchildren and is having difficulty coping and is feeling depressed has limited sources for help in her own language.

The examples are endless. These are people with real problems whose needs we urge you to keep in mind as you undertake your important work.

We strongly urge your committee to make recommendations supporting the implementation of a funding formula that reflects population needs, size and growth on an ongoing basis, and of a strategy to address the current funding inequity which is denying access to many residents of Ontario's fastest-growing communities. We believe that the prevalence rates and the economic costs of mental illness and addictions, now well documented, warrant such an aggressive strategy and the investments required to support it.

We look forward to submitting to you a more comprehensive report in the coming months. Thank you for allowing us to make this presentation.

The Chair (Mr. Kevin Daniel Flynn): Thank you, John, and thank you, Sandy. We've got time for two quick questions, I think, starting with the government and then perhaps from Christine or Sylvia. Helena?

Ms. Helena Jazcek: Thank you very much for your presentation. I'm extremely familiar with the issues, coming from York region and being the former medical officer of health. I think our first report, *York Needs Services!*, was 1988.

If suddenly this funding formula were to be addressed and redressed—maybe more for Sandy, coming from Peel—where would you put additional funds, should they become available, as it relates to mental health? Where are your, say, top three priority areas?

Ms. Sandy Milakovic: Early intervention and prevention, stigma and psychosis.

The Chair (Mr. Kevin Daniel Flynn): Thank you. Any questions, Sylvia?

Ms. Sylvia Jones: Yes. It's good to see you again, John. Thank you. I must say, part of the reason I'm sitting

on this committee is because of the many presentations I've heard and read with Fair Share, so well done.

My question relates somewhat back to Helena's in terms of point of first contact, assessment. Where do you see that most appropriately happening? Is that through the family physician or is there another scenario that you see playing out with mental health?

Mr. John Huether: My sense is that there isn't one point of first contact. In the earlier presentation, you heard from Cathy Dandy about how schools and hubs for kids are an excellent place to start for many youth, and we would echo their efforts within Peel to build some of the kinds of hubs that Cathy was referring to. We would echo her comments about the kinds of changes that need to happen. Family physicians are important sources, but also social services, child care centres, seniors' centres, the whole range of resources. I think we need to build changes in the system by paying attention to a number of capacities to deal with first contact.

The Chair (Mr. Kevin Daniel Flynn): John and Sandy, thank you for coming today.

LOFT COMMUNITY SERVICES

The Chair (Mr. Kevin Daniel Flynn): Our 9:55 presentation is not here yet, but our 10:10 is here a little bit ahead of time and is prepared to come forward. Terry, if you'd like to come forward and make yourself comfortable. Thank you for agreeing to move ahead a little bit. It will keep us all on track.

Mr. Terry McCullum: No problem.

The Chair (Mr. Kevin Daniel Flynn): You've got 15 minutes like everybody else. If you'd leave a little bit of time at the end, that would be great.

Mr. Terry McCullum: Yes, I'll try to speak in a way that, maybe if you have questions, allows that. Congratulations to all of you for doing this work. It's so important, and I'm so encouraged that the Legislature has an all-party committee. It's an extremely important topic that's often been hidden and needs to be talked about more.

I'm presenting on behalf of LOFT Community Services. It's one of the largest community mental health and addiction agencies in the province, although we may not be a household name by any means. We serve about 3,000 people each year in Toronto and York region in a variety of ways. Through an extensive supportive housing program in over 70 sites, we're serving 880 people in properties we own, lease, or rent, and in other people's buildings, like public housing. We also do individual case management support, individual services to 600 people throughout the community, and we do outreach in Toronto and York region: in Toronto through a program for street youth involved in the sex trade, of which 70% have some serious addiction issues, and in York region through a homeless outreach network, which is a partnership project I'll talk about.

LOFT is committed to supporting health and recovery for people with mental health and addiction challenges, especially marginalized populations, people who fall into

the gaps in service and people for whom there are no services.

1000

LOFT is a transfer payment agency, but we are also a charity. Each year we're putting in a million dollars—a million dollars—for unfunded areas, and they come right now in two big areas: transitional-age youth and seniors. I'll talk about those as we go along.

My presentation is, we have some great things going on that are newer, we have some special needs, and I believe we have a profound need for a paradigm shift in how we do services altogether, so I'll talk about that—just that; that's all. It's all in my paper, if you have questions.

Positively, with the LHINs coming in, I think some really good things have happened. It's been an occasion to bring people together in the community. We always had that, but the LHINs have made it more formal. I'm personally co-chair of the mental health and addictions steering committee for Toronto, and we're highly involved in York region. It's great when community partners can formally come together and not just informally, which we always did. This is more formal. There's a direct link into the LHIN structure, so that's good.

There has been positive work around stigma, and around social policy, through the Mental Health Commission of Canada, even through the discussion paper that's out, and the history of policy in the province.

There has been widespread acceptance of recovery thinking, which is broader than medical model thinking in mental health.

There have been a lot of integration activities. You're going to hear lots about that. LOFT is involved in a number of them. The homeless outreach thing in York region is a partnership of 11 agencies, both mental health and non-mental health. Last year we started a program in the Jane-Finch community for seniors and mental health, right in public housing, in a partnership model with three other agencies.

We're involved in a mental health project with homeless and HIV people. We're also involved, most significantly, as the lead agency for a coordinated access project for 29 supportive housing agencies in Toronto to link their services, have common waiting lists and transparency of admission. I think it's fabulous.

I could go on. I think some of the electronic stuff that's possible for us is fabulous because it will make it known to everybody, not secretive to look up in a manual somewhere. Okay, that's great stuff.

Moving along: special needs. You'll hear many. I'll just pick three: transitional-age youth; seniors with mental health challenges; and the method of supportive housing.

There is a big gap area for transitional-age youth. Everyone will tell you we need more money, and we do, of course. But the children's sector is well funded—I shouldn't say that, maybe. It's funded, whatever, up to the age of 18. There's a gap area between 16 and 18. But

after 18, boy, everything drops. That's why we call them transitional-age youth, because they're transitioning between the children's and adult systems. There are some things going on, for sure, but this is a big gap area.

We work with some of the children's agencies, and you talk with children's aid societies and other agencies. They're really concerned about this group. In our street program for kids in the sex trade, we see about 800 kids, and that's just in one area of Toronto, the downtown. Half of them come from child welfare, many have serious issues, and they're not connecting to services, okay? They will be the adults of the adult mental health system—certain of them, anyway. We need to really look at that area. We house about 60 transitional-age youth, at any given time, in 10 sites.

One of our programs is for women and addictions. Things can happen for that group that are positive. I just point it out as a need area.

The other is seniors. You're hearing a lot about seniors these days, but not seniors with mental health challenges. Often when they think about seniors with mental health challenges, they think Alzheimer's or dementia. But you know, there are other people too who have mental health challenges, including people now who will be becoming seniors. We haven't planned for them. Traditional seniors' services have a nervousness around this group. They're seen as disruptive and hard to deal with and they don't want them, so they fall back into agencies like us who run with skeleton crews to serve them.

If you were a board member, you might think, "Where's the risk management in all this?" We had a fire this last summer. Fifty seniors, including some with wheelchairs, or walkers, rather—two staff on duty. That's all we could afford. Thank God, everyone was out in four minutes because we had everyone fire-drilled. But no one would take those people, right? Someone has to take them, so they go to hostels, the street or back into hospital.

Supportive housing is a wonderful way of creating a normalized environment for people to live in the community, and we have many fine examples through the province. LOFT has a range of support options, from our higher support—we can do 24-hour, especially with the seniors' groups—down to no on-site at all. That's the majority of ours, but we have support options for them. So LOFT is an integrated service provider. We're not siloed into one area; we do many things. We integrate that. LOFT actually supports about 14 different programs which could all have their own boards and be agencies, but they're not. They're part of one integrated effort and we have a management system to support that. We could add new programs because of it.

Those are some special needs areas I'd highlight and one solution area: supportive housing. We have only one way of funding supportive housing today, called rent supp. It doesn't fit for some parts of the province, especially around places like Sudbury or York region where you don't have a lot of single units to rent, even if you have the rental support money. Plus, when the federal

government comes in with capital monies to build new housing, we can't apply for those grants because we don't have the support dollars to go with it or the rent supps aren't available. The city of Toronto did a housing proposal call recently and there were only two non-profits out of 48 applicants because nobody can afford to apply. So we need to look at that stuff. Sometimes the devil's in the details.

My last point—last but not least—is we need a profound system change. For over 20 years, the province has been committed to switching from an institutionalized-based kind of funding for mental health and addictions to a community-based. In its policy documents—I quoted one in here. Back to even 1999, they talked about 60% community funding, 40% more institutional. That's never happened, and it isn't happening now. Just as a statistic, 85% of the Toronto Central LHIN's funding is institutional and only 15% community. In the Central LHIN, it's 90% institutional and 10% community. Everyone says the community is the answer, right? Hey, people need services in their local community, person-to-person and on their streets, and yet the funding doesn't support that.

Other constituencies, like the UK and New Zealand, have done some really dramatic things. They haven't saved any money. It's the same amount of money, but they reallocated it; they did it differently. You have to believe it can be done, and it can.

In the LHIN structure right now, the role of policy is with the province. It's really a provincial responsibility to set policy and direct the LHINs around this. How could a LHIN take the risk on their own if that wasn't the policy, even though it's been the policy for 20 years?

The current document about "the right door" says that the system has to be funded within its own capacity right now. There will be no new money. That means the status quo must continue. You can make incremental little changes, but basically the paradigm you have now will exist. And I would say to you, Ontario loves institutions. They just love institutions. The answers are in institutions, and that's where all the cost is too, by the way.

For seniors, we put all our eggs into the basket of hospitals, long-term care and nursing home facilities and then we found out—surveys showed that up to 53% of the people on the waiting lists for nursing homes could actually be served in the community.

CAMH did a study years ago that showed that up to 90% of the people in psychiatric hospitals wouldn't need to be there if there were community resources. You've probably seen the Auditor General's report in Ontario on mental health and addictions. Well, it's true. Everything in that report mostly is true. You have an unbalanced system. You hear about children's mental health. At least with children's mental health, they have a community system. It's hardly institutional at all. It's mostly all in the community. We don't have that in adult mental health. When people like Peel come to you, York region and others, and say they need more of a share, they do, but we need to put it in the community. So it's how you think about the thing. It can work.

People have an inner strength. If they have the right supports, they can live their lives. That's what recovery thinking is all about, that even though you have mental health and addiction challenges, you can live a successful life in the community with the proper supports and orientation. It is a lifelong process, though.

1010

One other point; I haven't got it in the paper. I think you're going to see from your hearings here that there are so many fabulous people working in the system. I think you will probably conclude that. I certainly feel that way about everyone I've met across the province and here.

The Ontario Federation of Community Mental Health and Addiction Programs: If you look at their budgets, most of the agencies in that organization have their budgets under \$1 million, or even under \$500,000, so how is that community care? Those are tiny operations, if you're really trying to be comprehensive.

I'll stop at this point, and I wish you well with your tasks. But I hope you will think about the big picture and a policy about affecting the big picture. At least get us back on that course of shifting the paradigm. Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Terry. I appreciate the presentation. We've probably got time for two quick questions, starting with Sylvia and Christine.

Mrs. Christine Elliott: You've touched on so many things that I hardly know where to start. But I would like to ask you one question about working with homeless people and with youth. We certainly hear anecdotally that a lot of people who are homeless have mental health problems. First of all, is that your experience? Secondly, how do you get people to get into your homes if they're people who are chronically mentally ill and maybe don't want to initially? Do you just keep up the relationship with them or how do you get them, I suppose, to want to come into one of your homes?

Mr. Terry McCullum: First you have to have a home to get into. We took over a building for seniors that was falling apart, and we took in 110 people. It had a lot of vacancy because it hadn't been going so well for years. We took in 40 women from the women's shelters right away. You have to give people choice, but if they have a choice, they will come. To live in a hostel is not where you want to be. There is a significant percentage of people who have some mental health and addiction challenges, and that was not always talked about. It seemed politically incorrect but it's there. It doesn't mean all the homeless have mental health problems, certainly. But there is a group in there, and if we give them options and allow them to choose, a number will choose, for sure.

And then you asked about youth?

Mrs. Christine Elliott: Well, it's the same thing with youth. They're looking for a place, and if you have a home for them to live in, they will come.

Mr. Terry McCullum: Yes. You have to be a bit creative. If you think of your own teenagers, they're going to resist authority, right? So you've got to do this in the right way. I just made a joke, but in a way it's true.

You've got to allow them to live their lives with some freedom too. We have a house we started with women and addictions committed to abstinence. We said, "If we give you a house"—because they were saying, "Where are we going to live after this more intensive program?"—"would you run it?" They said, "Sure." So we call it peer support. They're committed to continuing in that, and they're doing well.

We have seven houses for transitional-age youth that have no staff in them, and we've been doing it since the 1980s. It seems to defy logic but it works if you do it the right way.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Terry.

Mr. Terry McCullum: Did someone else have a question?

The Chair (Mr. Kevin Daniel Flynn): No, that's it, and unfortunately your time is up. You did a wonderful job. Thanks for coming today.

Mr. Terry McCullum: Thank you for your work.

MRS. X

The Chair (Mr. Kevin Daniel Flynn): Our next presentation is at 10:15 a.m., if that person would like to come forward and make themselves comfortable. Sorry, 10:25—even though it is 10:15. Make yourself comfortable. There's some water there. Like everybody else, you have 15 minutes to use any way you see fit. It works a little better if you leave some time at the end for any questions, maybe.

Mrs. X: Thank you for the opportunity to speak to you today.

The previous speaker said something very important, and that was that you can lead a successful life with mental illness.

When I was growing up, mental illness was the lady down the street whom our parents told us to stay away from. Looking back, I'd guess she suffered from paranoid schizophrenia. As kids, we didn't understand, didn't want to, and skipped her house at Halloween. Twenty years later, I'm an ultra Type A Bay Street lawyer. I work ridiculous hours and I love every minute of it. I've been married to a wonderful man for more than a decade. I have a five-year-old son, which makes me an expert in dinosaurs, Star Wars and Harry Potter.

Two years ago I woke up in the intensive care unit of a psychiatric ward. I was there for six weeks. Since then I've been back four times. I've spent six months in that hospital.

Since I was diagnosed with bipolar disorder, I've learned a lot about the misunderstandings and stigma that surround mental illness. Too many of my friends and colleagues, who are intelligent, open-minded, compassionate people, had to really readjust their views in light of my illness.

I found that mental illness is often seen as something other than a "real" illness. There seem to be three aspects of this fundamental error. First, in most cases, when

someone is seriously ill, there are specific medical tests that produce concrete results. There are numbers and images and tracings and outcomes that are positive or negative or abnormal or not. Mental illness doesn't fit into that framework.

Second, abnormal changes in emotions or behaviour may be so gradual that they go unnoticed or they may be dismissed as unfortunate overreactions to life's ups and downs. If you care about somebody who is behaving oddly, almost anything, any explanation, is more comfortable to you than that they have a mental illness.

Third, there's a perception that mental illness isn't all that serious, especially when you compare it to other serious medical conditions. On that, I can only speak to my experiences with bipolar disorder.

To avoid killing myself, I have lived months of my life in three-minute increments, one to the next, telling myself that my family needed me. At the other extreme, I've stayed awake for four days straight, absolutely enraged that the rest of the world can't keep up with me. That level of involuntary sleep deprivation causes me to hallucinate.

I used to run from any room that had even the tiniest little spider in it. Recently, I went to a zoo. It had a tarantula called Rosie, of all things. The staff there recognize phobias: You're pale green; you're shaking; you're standing 20 feet away. It's pretty obvious. It took me 10 minutes to go that 20 feet. I finally touched Rosie, just so that the next time I have tarantulas swarming out of my walls and over my bed, it might not be so bad.

Some bipolar patients have intrusive thoughts which they can't ignore, no matter how hard they try. I know that what I hear isn't real and I know it never will be. If you have a child you love, you know what your worst fears are. That's what I hear, for hours.

Despite all this, for someone with my diagnosis, I'm lucky. I have a spectacularly good medical team. My primary psychiatrist is world-class, as is one of the sub-discipline specialists that I see.

I have tried so many medications in attempts to find the right combination that my pharmacist thinks I'm fascinating. I currently take at least five different medications a day. I have a rheumatologist to deal with one of the worst side effects, which is swollen joints which stop me from being able to pick up a coffee.

The psych ward nurses that I know are the kind of people who stop me in the street to introduce my family to theirs.

I also have a very wise and experienced social worker. Once, she looked at me and said, very calmly, "This illness nearly killed you. Your family is traumatized. You can't wait to get back to work but you can't go. You want control and you don't have it." And I felt better because she was right, and I was mad with myself for feeling sorry for myself at that particular moment.

Then she asked the question that really, really resonated with me. She said, "What happens if you know someone who is in hospital with cancer or a heart attack?" I said something about visitors and cards and

balloons and flowers and their co-workers signing up for the next 10K run. She just looked at me. In psych wards, there aren't balloons or cards or flowers and there are barely any visitors, because most people are too ashamed to admit they even have mental illness.

Whether you're aware of it or not, you probably know somebody with a mental illness. It might be family or a friend or a co-worker or the guy who orders his double-double at Timmy's at the same time you do.

1020

Mental illness can be terrifying, not just if you suffer from it but if you see it. Before I went to law school, I had a volunteer job. Late one night, I was out with an ambulance crew and they were trying to save a 60-year-old man who had tried to commit suicide. He had horrific injuries. They were a good crew. They were working on him, and I was kneeling on the floor and cradling him, and he was calling me Mommy. He started to fade. They got him to hospital, they treated his injuries, and he got psychiatric treatment. I saw him a year later. He was walking around and smiling.

So what do we need to do? Why are you here? Why am I here? We need to make the public understand that mental illness takes many forms and it can attack anyone at any time through no fault of their own. We need mental illness to be recognized as a physical condition that simply happens to manifest in a patient's moods, emotions and behaviour. We need our civic and political leaders to ensure universal access to treatment, to fund research, perhaps in hope of a cure, and to improve on the resources that we have now. CAMH itself is cause for optimism, but facilities for the mentally ill are still woefully inadequate—not just the inadequacies described by the previous speaker, but even for those who have access to our best mental health services. Even in downtown Toronto there are emergency departments holding patients for up to a week because they don't have psychiatric beds and they don't have psychiatric nurses. In one of Toronto's largest and best-funded hospitals, which I am all too familiar with, I'm told that there isn't actually enough to repaint this dismal, Dickensian ward.

Finally, we need to give people hope. Every fundraising ribbon that you see, whether it's pink or yellow or purple or blue, is a symbol of hope that a particular disease can be beaten. People donate because they care enough to invest in the hope of finding a cure. Two years out, I'm starting to have hope. My life is fundamentally different. I now live day to day. I have wonderful moments and I have awful ones, and I go to the hospital every 10 days for appointments. But it doesn't matter how uncertain my future is; right now, my treatment means that I can kiss my husband, hug my kid, and look forward to being a productive member of society again, whether that's working or volunteering or helping somebody else through the same problems.

You probably know that ad for the Princess Margaret Hospital—you know, that one where they all hold up the blue cards and then turn them over? The woman who holds up that sign saying "Given months to live ... four

years ago" is my son's teacher. For three years, she's talked to these little kids about dying and about chemo and about having the time to spend with the kids you love, doing the things you most want to do. Literally thousands of people who know her or know of her get a little jolt of hope and faith in the human spirit every time they see that ad. Unfortunately, there aren't clever and uplifting ads about mental illness. People can't even openly admit to having a mental illness and expect understanding and compassion.

It might sound trivial, but think about how we speak or how others speak from day to day. In our everyday conversation, "He's insane." "She's got crazy ideas." If you're neat, you are "obsessive." If you're depressed by trivial things, you are "depressed." If you are energetic, you're "manic." If you are worried about when your kids miss curfew, you're "paranoid." If you listen, you'll hear that language. It doesn't mean much, but it tells you about the way people think about mental illness.

There isn't a cure yet, but one day there will be, and if our leaders get behind a significant public education program, they'll have fired the first shots in the war to defeat mental illness.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for that presentation. You have left a little bit of time for questions, if you're prepared to take some.

Mrs. X: Of course.

The Chair (Mr. Kevin Daniel Flynn): Let's start with France.

M^{me} France Gélinas: I liked how you summed up your last sentence with how a public education program will be the first shot at winning the war. You've mentioned what Princess Margaret has done. Have you come across any positive messages or any ideas as to other jurisdictions where that have been successful in changing people's minds through a public education program?

Mrs. X: I haven't. I wish that I had. I've seen a very successful program in a hospital that seems to be addressing mental health issues in youth very well. But in terms of a broader, more successful education campaign, I haven't seen that and I've been looking for one for two and a half years.

M^{me} France Gélinas: The next question is personal, and you don't have to answer it. What was your first point of access to the mental health system?

Mrs. X: An emergency ward.

The Chair (Mr. Kevin Daniel Flynn): Thank you. Any further questions?

Mrs. Liz Sandals: You spoke about a number of different mental health professionals that you work with in one way or another, so you seem to be working now with quite a comprehensive team. I'm wondering how you got connected to that team, because my sense is that in many cases people are much less successful in getting connected to that medical and social support team.

Mrs. X: They absolutely are. From my experiences working with people living on the street and in various other circumstances, there is a huge number of people who aren't getting that kind of care.

I was fortunate, probably for a number of reasons that are unacceptable reasons to be fortunate. I have ferocious advocates. I'm articulate enough to be able to explain what my problem is so that it can be specifically treated. I'm medically interesting, according to a couple of doctors. My treatments have been atypical, so there is a certain amount of sharing of, "You've got to see this one." I'm also stubborn, and if somebody trivializes the situation and says, "You're not within 20 minutes of killing yourself. You need to go home," originally I would have taken that and I would have gone home. I've now learned that you have to say, "That's not going to work." Sometimes I'll do it at home; sometimes I need to be here.

Mrs. Liz Sandals: So you've got a lot of interpersonal skills that don't come with the average patient.

Mrs. X: I'm also—unless you love me, I'm not frightening. When I'm hallucinating, I retreat into myself. I don't start lashing out at people physically or verbally. I don't suffer from paranoia or delusions. I come from a well-to-do background, so at a certain level I'm not somebody whom people want to get out the doors, and I've worked with, for example, homeless people. I would go with them to the hospital and I was the one arguing that this is a person who is just as entitled to treatment as the next bed over.

1030

Mrs. Liz Sandals: So perhaps our challenge is to figure out how to get everyone the level of treatment that you have received, and also to deal with the stigma.

Mrs. X: That's absolutely critical, and I think that until the public understands that mental illness is beyond someone's control, that it's not a weakness and it's not a failing, and they stop seeing it as a fault, then they'll start seeing it in people who they know, people will admit to it, and they'll start realizing it's a widespread problem, and then they'll realize that it's entirely unacceptable that all Ontarians don't have access to the same kind of treatment.

Mrs. Liz Sandals: Thank you very much for sharing.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today.

NEASA MARTIN

The Chair (Mr. Kevin Daniel Flynn): Members of the committee, our 9:55 a.m. has arrived now, so I'm going to ask Neasa to come forward. We had somebody else step into your spot, so we're still not too far off schedule.

Mrs. Neasa Martin: Thank you very much, and I can only express my deep apologies for the delay in arriving.

The Chair (Mr. Kevin Daniel Flynn): That's fine. You're here, and as I've explained to everybody so far, everybody's got 15 minutes. You can use that any way you see fit. If you leave a little bit of time near the end for some questions, that works out well usually. The floor is all yours. Make yourself comfortable.

Mrs. Neasa Martin: Thank you. I'd like to just mention that your question about, "Are there any examples of

campaigns that have been effective in addressing stigma and discrimination and enhancing social inclusion?"—that's what I'm here to talk to you about today.

I'd like to thank you for taking the time to meet with me. My original request came through a protest around the imminent closure of the *mindyourmind.ca* program, which is an award-winning, internationally acclaimed, anti-stigma education awareness program targeted at teens. It was incredulous to me that such an example of excellence was at the risk of being lost to our community, and I thought, "How is it possible?" I'd like to thank the Honourable Deb Matthews for giving a reprieve to the program of one year so that it could demonstrate its effectiveness. The thing that made me want to speak to you is that I think this is an example of where public policy and funding are reflective of the broad-based discrimination that people living with mental health problems experience on a day-to-day basis.

On the issue of mental illness, I am not a neutral observer. Mental illness has been an active and continuous part of my life as a daughter, as a sibling and from a personal perspective; I also suffer from a mental illness. I know only too well the negative and harmful impact an untreated mental illness complicated by substance abuse can cause in a person's life and the long shadow it casts. I understand how easy it is to see yourself as broken and fear the risk of becoming one's genetic destiny.

For over 25 years I've also worked as a mental health care professional, and I've worked in every area of the system: in-patients, outpatients, community case management, rehabilitation, community consultations, capacity building. I've learned from this experience and seen first-hand how supports and services fail to foster hope, optimism and a belief that recovery is indeed possible, and are frequently misaligned to help people maintain friendships, kinships and a foothold in the world of work.

For the last seven years I've been working as an independent consultant at both the provincial and federal level with an eye to trying to find those critical points of influence where we can achieve transformative change, because transformative change is what is needed.

I've worked with the OLCG, when it was known as such, on developing a responsible gaming strategy, and it remains today clear to me that profit continues to trump social responsibility on this gambling issue. I've researched the connection between mental health and problem gambling, and in fact, the connection is very strong that people with mental illness are more vulnerable to developing problems.

I've recently consulted with the Mental Health Commission of Canada in helping it develop its national stigma and discrimination reduction strategy, and helped them frame recovery from a consumer perspective in the creation of a discussion document.

I've just completed a research study on quality of life for the Schizophrenia Society of Canada, trying to find out what "quality of life" means for people living with mental illness and their families. I've just finished a

project up in North Bay with the North Bay General Hospital and the Northeast Mental Health Centre, helping them to reduce the stigma and discrimination as these two enterprises come together in a new location. I've just returned from Australia, where I delivered a keynote address on social inclusion, and I'm working right now with the Queensland alliance to develop an evidence-based stigma reduction strategy with a mind to social inclusion. So I come with a fair bit of experience and knowledge.

I see in the provincial strategy that there is a desire to address stigma as a priority. To do this, you will need a strategy. Good intentions won't be enough. The emerging research is very clear that having a comprehensive strategy does work. There is economic modelling that shows that it is also cost-effective and that it is far more expensive not to undertake this kind of approach.

Stigma and discrimination and social exclusion, as you well know, are critical. It's widely acknowledged as a problem. There's a high degree of agreement that we should be doing something, but there is no agreement on what that something is. There are many programs that are under way right now; many are based on intuitive understanding, not on evidence-based research. Hardly any of them are being evaluated, although the Mental Health Commission is developing strategies to increase the research on what's being done.

It's thought that any activity that is focused on stigma and mental illness is inherently stigma-reducing, and that is not true. Stigma, as you know, impacts on every area of life. I'm sure you've heard from people that it's worse than the illness itself and, in fact, continues long after successful treatment. So enhancing treatment is not going to be enough to remove the discrimination that people feel.

It affects your self-image, your self-esteem, your mood. In the worst cases, it causes people to end their lives. It prevents people from seeking help, from staying in treatment and, as a result, not getting access to good-quality care. Self-stigma is when people absorb the negative feelings around them and make them their own. This is highly corrosive and contributes to the way in which people will not approach the health care system. It starts when people feel different and "other," and that's reflective of the way in which the world sees people with mental illness as abhorrent and different. It's reinforced in people's contact with the health care system through the process of receiving a diagnosis and starting medication. It's pernicious, it's pervasive and it's all-enduring.

Having a diagnosis of mental illness also leads to overt discrimination and the denial of people's rights. People will not get employed, they won't get life insurance, they can't get disability insurance; mortgages are denied. Even the right to travel is restricted when you have a diagnosis. It's critical that we start to shift our thinking away from seeing this as an illness-based issue and into a social rights and human rights issue.

Let's talk about what works and what doesn't. I have spent the last couple of weeks researching thousands of

literature papers. What really is clear to me when you start to look at the research is that consumers are the critical experts on this issue and that the research has followed their insights, whether it's on the importance of recovery, the need to focus on having a friend, a home, a job, purpose, meaning, value, and the value of peer support. I used to run a peer support program in Ontario. It was extremely difficult in the early days for people not to see this as something dangerous and not to be supported, where in fact the research now is showing that the most effective way of reducing self-stigma is through peer support, group identification, participating in advocacy efforts and that sort of thing.

We've never been in a time when there has been more information about what mental illness is, what its treatment is, what its signs and symptoms are, because the most prominent approach that we've used is around mental health literacy. The assumption is that if everybody understands what these illnesses are and sees them as not a character weakness, not your fault, but as an illness like any other; if we teach about signs and symptoms; if we emphasize the potential risks of morbidity and mortality; if we emphasize the science around the illness, that that will in fact help.

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Despite these efforts, stigma and discrimination are actually increasing. The work by prominent researchers who map public-attitude surveys are noticing that now the public is more aware of what mental illness is, and its signs and symptoms, and accept that it's a genetically based and biologically driven illness. They're more supportive of funding for research but they also hold much more stigmatizing attitudes. There's this paradox that the more you know, the less you want to have to do with people with mental illness. So it's critical that we get the framing of this approach right.

There's also an increased belief that people with mental illness are dangerous and incompetent, and people want more social distance. There's also a decreasing belief that recovery is possible.

Where is less stigma? When the public understands that mental health problems are a response to social stresses, to a history of loss, and to experiences of trauma and abuse, that they are illnesses but that they are normal reactions to life and that they are part of our shared humanity.

People are more accepting when they see mental illness as part of a continuum, much like "normal" with the volume turned up. We understand now that depression and anxiety are acceptable because they feel as if they're part of our human experience.

People are more accepting when we use descriptors rather than diagnoses in our education and if treatment is perceived to be successful. There is also less stigma in societies where services are being provided, particularly at a community base. The policy neglect of government plays a critical role in contributing to stigma and discrimination.

Mental health care providers—professionals like myself—have played a major role in defining what reform

should look like. But the research is also very clear that mental health professionals hold much more discriminatory attitudes, also want more social distance from people living with mental illness and tend to take a paternalistic approach to treatment and routinely deny people basic rights and freedoms; that the over-focus on medication and medication compliance is part of that; and that, as a result, we do not see the development of services which are recovery-focused because many mental health care providers continue to hold the belief that recovery is indeed not possible.

The focus has been on disabilities and not strengths, and that when people refuse involvement with treatment services, it's more of a symptom of the illness than a protest against the quality of care that they receive.

It also is felt, through health care providers, that when you have a diagnosis of mental illness you are less likely to be investigated for other physical illnesses, although people with mental illnesses have more chronic illness. People have much poorer health care, shorter lifespans, suffer from more chronic illness and they're less likely to be investigated and treated.

Research with consumers about what their experience is: They say, "What's important to me is I want to participate in the community. I want to work. I want to enjoy a meaningful, purposeful life and be accepted by family and friends. I want to be able to access recovery-focused supports in my community."

Research shows that quality of life, and medications and treatments, are really critically linked, but when they support independence; that there's too much attention paid to medication and treatment compliance; that people are seen as a diagnosis and not as real people; that they're looking to be treated with trust and respect, not judged and criticized. They're looking for partnerships with care providers where they feel in partnership with, and not a sense of having power over, their decision-making.

As I mentioned, there are five international jurisdictions right now that have comprehensive social inclusion strategies, and one of the three most effective strategies that they have used is education—not education about illness, because that brings its own problems, but education that challenges the myths of what a person with a mental illness looks like, and that's best accomplished through personal contact. Having the experience of meeting with people with mental illness is the most consistently effective way of shifting attitudes and behaviours. And protest: Protest is an important one. The consumer movement has been actively involved in protest, and in fact new research is starting to say that that very act has protected them from the self-stigma, has helped them to reframe their illness as something meaningful and important to them rather than something broken that needs to be fixed.

The Chair (Mr. Kevin Daniel Flynn): I've got to tell you that your time's up.

Ms. Neasa Martin: Okay.

The Chair (Mr. Kevin Daniel Flynn): But if you want to wrap up, you've got about 20 seconds left.

Ms. Neasa Martin: My apologies. My recommendations to you are that if you want to reduce stigma and discrimination, make it an active campaign, with strategy that partners with key stakeholders; that consumers and leaders take a leadership role in that; that you focus not on education about mental illness but education about rights; and that you look at policy changes as well. One of the critical things is work. Remove the barriers to work. The Ontario disability support program still represents a huge barrier for people—that is within your domain to change—and make recovery outcomes and social inclusion goals as the measure of whether the supports and services that you're funding are being successful.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much, Neasa. That was very good. We got your point.

KINARK CHILD AND FAMILY SERVICES

The Chair (Mr. Kevin Daniel Flynn): Let's go on to Kinark Child and Family Services. We have Peter and Tracy with us. If you'd like to make yourselves comfortable. I'm assuming we still have some clean glasses there if you need any water. Like everybody else, you've got 15 minutes. Thank you very much for coming today. Use that time any way you see fit, but if you want to leave time for some discussion at the end, that seems to work well as well. It's all yours.

Mr. Peter Moore: Thank you. Good morning. My name is Peter Moore, and I'm the executive director of Kinark Child and Family Services. This is Tracy Folkes Hanson, who's our director of communications at Kinark.

Today marks the first day of the school year in many Ontario jurisdictions. Several of our clients, including a girl I'll name Emily, will be joining classrooms across the province thanks to treatment and services they've received. Emily had a difficult path in her early school career. She had trouble concentrating, had difficulty with anger management and was the brunt of bullying in the schoolyard. She is now a success because of the counselling, intensive family therapy and specialized school supports she received. It's important that we celebrate her success, but we also need to shine a light on the kids we don't see.

We're pleased to be here presenting to you, and commend the Legislature for supporting the establishment of a Select Committee on Mental Health and Addictions for Ontario. It is certainly time to talk about the importance of mental well-being as well as the urgent needs facing individuals with mental health problems, particularly, in our opinion, children and youth. I know you've heard from many of my colleagues about the chronic underfunding of mental health and addiction services for children and youth.

In my time with you I'd like to give you an overview of children's mental health, but I'd also like to focus on three issues which may not have been addressed previously: (1) the need for a population-based approach

to mental health and children's mental health; (2) the urgent need to address the mental health issues of our youth justice population in Ontario; and (3) the plight of our First Nations children in southern Ontario, and most particularly in the far north.

1050

To begin with, and by way of background, I'd like to tell you a little bit about children's mental health and Kinark services. Hospital-based services provide a small percentage of specialized children's mental health programs. The majority of services for children and youth are provided in community-based centres. These are not-for-profit organizations like Kinark that offer a range of treatment programs in their offices, in family homes, at community centres and in schools for children and youth, ages zero to 18, and their families. Children's mental health centres are located throughout the province and are funded principally by the Ministry of Children and Youth Services. Services range from prevention and early intervention to intensive treatment services.

Let me speak briefly about cost. The average cost of treating children's mental health problems in community-based agencies is less than \$2,500 per child per year. The cost of incarcerating a youth through the juvenile justice system in Ontario is over \$90,000 per year, and the cost of a pediatric hospital bed is more than \$900,000 a year. If I can just take you through that again: \$2,500 per child, per year in community-based care; \$90,000 per year for a youth in the youth justice system; \$900,000 for a pediatric hospital bed.

Kinark is the largest children's mental health organization in Ontario and provides professional help to over 10,000 children and youth with chronic and multiple mental health issues every year. I know some of you are familiar with us as we have programs in your constituencies. We partner to deliver services with child welfare agencies, schools, child care centres and community organizations. Our services are divided roughly into three main areas: child and youth mental health, autism, and youth justice. We run the Syl Apps Youth Centre in Oakville as well as a number of community-based justice programs.

The number of children and youth in Ontario who need our assistance is staggering. We know that one in five children in Ontario currently struggles with mental health issues. Only one in six of these children receives treatment. Each of these children and their families needs help, and each of these children is surrounded by a classroom and a neighbourhood that are affected by these problems. So, statistically, most of us in this room are personally impacted, directly or indirectly, by the issues of child and youth mental health.

Hand-in-hand with the volume of need is wait time. Families often wait weeks, and in some cases months, to receive treatment and service. If parents had to wait days, let alone months, to fix their child's broken arm or leg, the public outcry would be deafening. The wait time suffered by parents and their children is compounded by stigma and discrimination—and I know you've heard

something about that this morning. A national study conducted by Kinark in 2007 resulted in 38% of Canadian parents acknowledging that they would be embarrassed and ashamed to admit that their child suffers from anxiety or depression.

It's time we recognized that mental health is as important as physical health. Untreated mental health issues often become more severe, increasing the likelihood of school failure, family breakdown and involvement in youth crime. We know that we all deal with mental well-being at different points in our lives. These are often minor issues. We know that for serious mental health issues, treatment does work. We also know that evidence-based prevention and early intervention programs for children are effective, leading to all kinds of improvements: academic progress, social development, behaviour and mental well-being.

So what are we to do? In these turbulent economic times, we need cost-effective programs that can intervene early, a population-based approach providing the right amount of support at the right time in the most cost-effective manner possible. At Kinark, we are investing in evidence-based programs with proven track records. One example of a population-based service, which we have introduced in some regions in the province, is Triple P, which stands for the positive parenting program. Developed in Australia, it has been implemented in a number of countries and has been tested by a myriad of independent studies. Documented in more than 70 published studies, the Triple P approach has been shown to prevent or reduce social, emotional and behavioural problems in children, freeing them from reliance on medications or costly therapies. I'm pleased that its founder, Dr. Matt Sanders, has been invited to speak at a conference sponsored by the public agency of Canada next week, and I encourage members of your committee to investigate the merits of a broad, population-based approach to mental well-being.

In the Senate report *Out of the Shadows at Last*, tabled in May 2006, Senator Michael Kirby wrote that if mental health is the orphan of the Canadian health care system, then children's mental health is the orphan of the orphan: "We have neglected an entire population of youth struggling with mental health issues."

We know that 80% of youth in our youth criminal justice system have a mental health disorder. Senator Kirby has called these institutions "the asylums of the 21st century."

In his *Roots of Violence* report, the Honourable Roy McMurtry recommends that funding be targeted to the mental health issues of our youth. This is the only recommendation in his report with specific dollars attached.

In your examination of the mental health needs of Ontarians, I urge you to look at the neglected population of youth in conflict with the law. For the economy and the well-being of all of our communities, we need to deal with these kids' underlying mental health issues.

Finally, I appeal to you to take a leadership role with the marginalized population of aboriginal children and

youth—that we in Ontario become an example for all of Canada.

Kinark has been asked to intervene in a number of fly-in communities in the far north. These requests have come from the First Nations leaders in those communities. I am pleased to report that we have had some success by introducing western mental health expertise to traditional healing measures and looking to local communities to build on their own strengths and develop their own solutions, including giving youth a voice in the process. We are now being asked to replicate this work in other fly-in communities in the north as well as First Nations communities in southern Ontario. This is not a panacea for the complex social and economic issues facing our First Nations people. Rather, it can be an important first step to significantly reduce or even eliminate child suicides and give youth a voice, which is in and of itself an important step for mental health.

Summarizing, then, change starts with children and youth, where preventive measures and early intervention are most effective. We need to examine how these changes will have an impact on our service delivery and how we can work together to give youth their own voice and empower them to speak about their struggles, finding solutions that work best for them; recognize that Ontario's youth population is shifting; discover ways to build multi-faceted, community-based programs for the whole province, including our First Nations communities; and support the development of population-based, evidence-based programs and services to meet the ever-changing needs of the children, youth and families of our communities.

We need to create awareness of the issues, eliminate stigma, and champion the rights of children and youth with mental health challenges by delivering effective programs and treatments that meet the needs of our population. There are half a million children and youth in Ontario with mental health problems who deserve and need our help—half a million children who live, play and go to school in our communities. I urge you to give these issues serious consideration in your deliberations.

Thank you for your time.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Peter. You've left a little bit of time for questions, just over five minutes. Let's start with the government side. Helena? I think I saw you first.

Ms. Helena Jaczek: Thank you. Lots of questions. Specifically, I'd like to hear a little bit more about the Triple P, positive parenting program. I presume you involve the child as well as the parents. It's not entirely clear from the brochure.

Mr. Peter Moore: Absolutely, but it really is focused mostly on the parents. There are five levels. It goes from kind of a media blitz to let people know about how important parenting is for children, and then there are more intense levels. A second level has tear-off sheets to give to parents if they have problems, say, with bed-wetting or some minor kind of problems that they're worried about, so they don't have to get involved in something that's intrusive.

They go on the basis of minimal sufficiency, so whatever level of need the parent has, they tailor the intervention to that need. In York region, for example, we have involved the school boards, public health nurses, all of the children's mental health centres and the teachers so everybody is speaking the same language about parenting. If a parent goes to a parent interview in a school, the teachers can talk the same kind of language as therapists would talk.

As I say, it's population-based. It is mostly focused on parents, but it has a huge impact in terms of effect and also cost savings.

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Ms. Helena Jaczek: Just as a follow-up, suppose that during the process one of the counsellors realizes that there is in fact a really serious issue. I presume that you would continue on and make that kind of referral—

Mr. Peter Moore: Oh, absolutely.

Ms. Helena Jaczek: —because we've heard about early intervention over and over. So it's sort of a continuum that would—

Mr. Peter Moore: Absolutely. This isn't a panacea for all mental health problems for children and youth, but really, if you focus on parenting, that's a huge step to eliminate mental health problems—and you intervene early. So at Kinark, for example, we have a program at the front door. We've been able to reduce our wait time from 51 days to 19 days, and we've done that by using Triple P and using brief therapy. But if the therapists pick up that there are deeper problems, then they'll route them over to more intensive services.

Ms. Helena Jaczek: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Let's move on. Christine or Sylvia?

Mrs. Christine Elliott: Thank you. I'm interested in the issues of youth in conflict with the law. It's something that we haven't heard that much about yet and I'm wondering if you could tell us where you normally would get involved, what your involvement would be. And I believe there is one youth mental health court that we now have in operation; I wonder if you've had any experience with that.

Mr. Peter Moore: Our clinical director, Dr. Dick Meen, has had some involvement with that—it's in Ottawa, I believe—but no more than that.

Dr. Meen has a saying that children would rather be bad than mad, so it's more acceptable to have behaviour problems that relate to youth justice than to have mental health problems. I think these kids go through a different door—if they slide one way, then they'll get involved with the youth justice system; if they slide another way, then they may come to us through their family doctor. There's a range of services for youth justice clients. Our experience is that behaviour control is much more important than the underlying issues of mental illness—our psychiatrist again says that behaviour is the language of children, so if we get underneath what the behaviour is and look at what the causes of the behaviour are.

We have some non-residential programs. Multi-systemic therapy would be one example which we

operate in Durham region and York region and Simcoe, and that's an intensive, community-based program for kids in conflict with the law. Then you go from that to open custody to secure custody. I'm not sure if I'm answering your question. There are diversion programs, but I guess my point in my presentation is that it's more often the behavioural control than the underlying mental health issues. So if that's not dealt with, these problems, I think, will recur. That's been our experience.

The Chair (Mr. Kevin Daniel Flynn): Time for one very brief question and answer, France.

M^{me} France Gélinas: Sure. You mentioned that you have gone into First Nations communities and have been able to bring white people medicine with traditional—does this program have a name, and where was it and could we know a little bit more?

Mr. Peter Moore: It was in Wunnumin Lake. It was at the First Nations children's aid society. Tikinagan had a rash of suicides of 12- and 13-year-olds in this very small fly-in community. We were with one of the supervisors at a conference and she stood up and spoke eloquently about how, "You think you have problems down here? Let me tell you what it's like up north." So, with permission from my board of directors, we were able to send a couple of clinicians up to talk to the mental health professionals in the community, the paraprofessionals, and got them involved in speaking about their issues. Our psychiatrist who went up there got a list of 40 children who the community thought had mental health issues. In fact, when he did his assessments, only one of those 40 children had a diagnosable mental illness, but there were lots of complex social problems—difficulty parenting in terms of the residential school experience, drug and alcohol abuse. So it's getting the community to work on those problems, to be available by videoconferencing, and to be consistent, to come back and have relationships with them and to be able to do very targeted interventions when they are needed.

The Chair (Mr. Kevin Daniel Flynn): Peter, thank you very much for coming today.

GRIFFIN CENTRE

The Chair (Mr. Kevin Daniel Flynn): Our 10:55 appointment is not coming today, but we have the folks here from the Griffin Centre ahead of time, I think. Laurie, if you'd like to come forward and introduce yourself. Make yourself comfortable. Welcome. Like everybody else, you've got 15 minutes. You can use that any way you see fit. If you can leave some time at the end for discussion, that always works better. If you'd introduce your colleague this morning, that would be great.

Ms. Laurie Dart: Good morning. We're very appreciative to be here this morning to meet with you. I will start by introducing my colleague. This is Zack Marshall. Zack is a supervisor at Griffin Centre, where I'm the executive director. We're going to whip through our presentation as quickly as possible so you have a chance to ask questions. I'll do my best at that and so will Zack.

We've reviewed the work of the committee and the various presentations to date. We're very impressed by the focus on this very important issue, the commitment of the committee members and the quality and diversity of the presentations that you've received. You've heard a great deal about how and why the mental health system isn't working, but we would like to take a bit of your time today to tell you some of our ideas about how it might be improved.

I've been the director at Griffin Centre for over 20 years and, prior to that, worked in mental health as a social worker and in senior management roles in various service sectors: children's mental health, youth justice and secure treatment and developmental services. All these experiences have shaped my learning and my strong commitment to building a system of mental health care that includes strategies and service models that create real accessibility for individuals who do not otherwise seek help from traditional services or for those whose needs are so great that one sector can't meet them. Many of the individuals with mental health challenges whom we see at Griffin Centre need significant outreach and ongoing support to make use of our services.

Zack and I will focus our attention today on three core issues that, if addressed properly, can make a huge difference in the lives of people with mental health and other concerns. The first one is improving access to supports and services. The second is developing partnerships, and the third is coordinating services across organizations and sectors.

First, I'll just give you a quick overview of what we do at the Griffin Centre. Griffin is unique in that it's a children's mental health centre for youth with a range of mental health needs, often exacerbated by other issues or challenges. For instance, many of our youth have learning and school problems, developmental disability, substance use issues, conflict with the law, newcomer challenges and many more. The centre is also a multi-service mental health organization for adults with a dual diagnosis.

We provide community counselling, in-home and in-school support, day and residential treatment programs and crisis supports via various access points and program sites across the city of Toronto. Our clinical staff seek to create every opportunity for our clients to make use of what we have to offer. We have a long history of creating new services that respond to emerging community needs. As well, we offer training and consultation via various partnership arrangements both locally and in other parts of the province.

We serve about 1,000 clients with complex mental health needs per year. As you've learned from previous presentations, an individual with a dual diagnosis has mental health needs compounded by a developmental disability. I know that you had Dr. Philip Burge here and he provided you with an excellent overview of the statistics related to dual diagnosis and the limited number of services that exist across all age ranges.

First, accessibility, or what we like to call barrier-free services: A typical barrier to service that Griffin staff hear

about frequently from our clients is the fact that individuals who have more than one diagnosis or mental health challenge don't fit into many of the programs being offered. For instance, a youth with a diagnosed anxiety disorder and a developmental disability and substance use issues may be excluded from another service because of his or her cognitive level of functioning and/or the substance use. People with more than one problem need services that can accommodate their unique situations and complexity.

Improving access has been a core value of the centre since its inception 34 years ago. However, talking about barrier-free services and providing them are two different things. At the Griffin Centre we've learned that this work needs constant attention. We know that people with serious mental health concerns also face a myriad of other problems as young people and on into adulthood: lack of success in school, aggressive outbursts, being bullied or bullying others, isolation, unemployment and homelessness. It's these circumstances and behaviours that often indicate underlying mental health problems. I think you heard a similar story from Peter previously. It is individuals in these circumstances who need prompt and flexible services and access to those services.

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Unfortunately, these issues are often addressed in isolation without recognizing or understanding what else might be going on. For instance, the youth who continually skips school and becomes verbally aggressive with teachers when asked to do something may in fact have a mild developmental disability that's been undiagnosed, a significant learning disability that may be undiagnosed, or may be struggling with issues of poverty, racism and/or other issues related to gender identity or sexual orientation. It's our job as professionals in that youth's life to find creative ways to get to know them and to engage them in a mental health support plan which will meet their needs.

If we really believe in the positive impact that mental health services can have on people's lives, it's our job as organizations to provide flexible services which can be put in place and adjusted as the needs change, to support clients through crisis, to help them with the critical issues in their lives, like housing, employment, money management and medication, and to help them to learn new skills. This takes time and patience, and a commitment to progress being made in small steps.

Individuals needing mental health services come from many different ethnoracial and cultural backgrounds and will not always see the benefit in services that are grounded in a western cultural approach. Griffin has continually reviewed its policies, practices and service models to improve accessibility and ensure that our programs are relevant to the lives of our clients and their families. Hiring staff from various communities; situating services within priority neighbourhoods—for instance, our Y-Connect program in the Jane-Finch community; creating safe and accepting program environments for our LGBT youth—which are lesbian, gay, bisexual,

transgender; providing evening and weekend access to crisis supports; seeking client input into their service plans and to the centre's program development; and continuous staff development related to diversity: All of these strategies contribute to barrier-free access.

Partnership development and service coordination: At Griffin, because we serve individuals with a variety of mental health concerns and other challenges, we know that to be most effective other organizations need to be part of the service model. It isn't all about us. To this end, the centre has built formal service networks that create coordinated access and service navigation assistance to a range of linked programs from various sectors.

It is these networks that form a system of care for the individual and family. Each organization commits specific services to the overall network of service and can access, on behalf of its own client base, all the other network components. This model enhances services and supports for the individual while also creating a support system for the partner organizations. The stronger and more diverse the partnership network, the more complex the needs of the individuals receiving service can be. The individual who needs a made-to-order and highly individualized treatment and support plan from services funded by different ministries benefits from this kind of network design and specialized service coordination. Instead of shopping around for a program that the individual will fit into, the services are organized to fit the individual and family, and ongoing support and coordination are provided.

In essence, our staff form the glue that integrates the services needed to create this individualized program. Based on our experience after many years of providing a service coordination function, which is called case management in some of the sectors, we know that there is a great need for more specialized service coordination for both youth and adults with complex mental health needs. A service coordinator with strong clinical and facilitation skills can make all the difference to the individual's success. Conversely, the lack of this support often leaves people confused and angry, struggling with mental health challenges while trying to get help, and facing rejection or inadequate supports. This leaves people with complex needs in crisis, bouncing between hospitals, shelters and the justice system. Increased service coordination efforts need to both address the immediate crisis and develop long-term stabilization plans for these clients.

Finally, to make the service network a truly effective strategy to support individuals with mental health needs and other challenges, there need to be strong inter-ministerial linkages which will support or encourage organizations to work together in providing a network of care.

Current government funding streams are based on specific needs and/or age groups: The Ministry of Health funds adult mental health, the Ministry of Community and Social Services funds developmental disability services, the Ministry of Children and Youth Services funds children and youth mental health services and the

Ministry of Education funds education. But mental health needs don't fit into life stages or lifestyle activities. They are, instead, all-pervasive and can be long-standing, requiring flexible, individualized and persistent responses. Formal interministerial agreements, like the dual-diagnosis guidelines that outline how cross-ministerial services should work together, are essential to encourage seamless services across age ranges and diverse needs.

Mental health is the essence of a person's sense of well-being and ability to cope. It can make the difference between children staying with their parents or requiring alternate care. It's the strength that underlies a child with a severe learning disability being able to succeed in school, and it creates a more stable workforce. It deserves everybody's attention.

Zack is just going to provide you with an example of one of our programs, and the clients in it, that illustrates what I've been trying to talk to you about.

Mr. Zack Marshall: Thanks, Laurie.

The Chair (Mr. Kevin Daniel Flynn): Zack, you've got about five minutes left.

Mr. Zack Marshall: Excellent. I will try to talk for about three, at maximum.

Good morning. Thank you for this opportunity to speak with you. I'm the supervisor of ReachOUT, which is our program for lesbian, gay, bisexual and transgender youth at the Griffin Centre. In the past five years, we've worked with over 400 youth, attempting to provide what Laurie has talked about as barrier-free services or accessible services for all LGBT people in our communities.

The youth who attend our programs typically tell me they don't fit into other agencies, and sometimes, to be honest, I feel like I can tell why. They may be experiencing a number of barriers, whether that's related to mental health issues, intellectual disabilities, homelessness, poverty—just a range of pieces of challenges that are confronting them at different points in their lives. They often are dealing with, as I said, mental health issues and substance use concerns and struggling with basic needs such as housing, employment and transportation.

They also are often dealing with what we call intersecting oppressions, such as racism, homophobia, transphobia, ableism—the list goes on. So we're working to try to help support them around those and to gain their own skills to deal with them in their lives.

To respond effectively, we've tried to combine a clinical model with a model that has more of a community development focus. A lot of programs do one or the other. We've tried to have both. This has meant offering more drop-in groups, increasing our youth engagement and holding community events in an effort to strengthen and build our communities.

As we have developed more of an awareness of the social determinants of health and their impact on well-being and mental health well-being, we've worked to offer a more holistic program which recognizes people's full range of strengths but also the needs that they have over time.

I wanted to talk to you about a couple of examples. One young person we work with was rejected by his family after they found out he was gay. We supported him over the past four years as he entered the shelter system, experienced hospitalization for mental health concerns and struggled with substance abuse. However, we were also there when he attended our weekly drop-in groups, for his graduation from a job training program and when he found stable housing. Providing holistic and accessible programming requires strong partnerships as well as advocacy and self-advocacy. As one of our young leaders, this client has continued to successfully gain facilitation and self-advocacy skills.

I have to be honest and tell you that very often I hear questions from the staff I supervise that I do not know the answers to, and I wanted to mention a few of them here, just because it might help you to see some of our struggles. Recently I had a question from a staff saying, "How do I support a client who has a \$9,000 cellphone bill?" I was quite mind-boggled. Thinking about this in the context of someone who's also on ODSP and doesn't do so well with their finances, obviously, but was really interested in talking every day to their girlfriend in the United States, we were trying to figure out, "Okay. How can we support this person?"

Another question was, "What is the best way to help a transgender youth who is experiencing harassment in the shelter system? How can we work with the system to support that youth better?"

Another staff came to me last week and said, "Zack, I just got back from vacation and found out that one of our clients is being evicted after a series of misunderstandings and miscommunications with the landlord. What can I do?"

I won't go on, but one other was, "A client we're working with does not have enough money to pay for her prescription antidepressants. How can we help her?" I know that we have many programs in the province and in the city that can respond to clients if this was maybe the one problem they were trying to deal with, but what's often happening with us is that there are multiple layers. So to respond even to the question of how to address the prescription medication costs takes a fair amount of work and service coordination on behalf of the staff.

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As I mentioned, I don't always know the answers to these questions, but we are working on figuring them out. The youth we work with are certainly an inspiring, amazing group of people. They also frequently experience significant difficulties with mental health, precarious housing, poverty and substance use concerns. While as service providers we face challenges in responding to their needs through accessible programming and these strong partnerships with other community organizations, we're able to support them and build and strengthen our communities.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Zack. You're about eight seconds over 15 minutes, so unfortunately there's no time for any questions, but you made a great presentation. Thank you very much.

GLENN BROWN

The Chair (Mr. Kevin Daniel Flynn): I understand that Reverend Brown is with us. I can pick you out in the crowd.

Rev. Glenn Brown: That's deliberate.

The Chair (Mr. Kevin Daniel Flynn): Come on forward and make yourself comfortable. Like everybody else, you have 15 minutes. You can use that any way you see fit.

Interjection.

The Chair (Mr. Kevin Daniel Flynn): Oh yes, absolutely; anywhere you're comfortable.

Rev. Glenn Brown: First let me explain the paper I distributed to you. I had explained to my congregation over several weeks that I was going to be making this presentation. With a medium-sized Protestant congregation in a suburb, I serve people who deal with a variety of problems, so I expected some intelligent comment from them that I might bring as part of this presentation. Many offered to write; only one did. This is the result of that one person's writing, so I'm not going to repeat what is in that paper. It's simply there for you to read.

I would only say to you that this is a person who continues to experience mental illness, and I'm told this person continues to have hallucinations, times of detachment from reality, and yet is fully employed and is a university graduate. I ask you to keep that in mind when you read this person's paper because it illustrates quite well this person's point that, although generally considered symptom-free, which in this person's opinion is really all that the system cares about, the fact is that this person experiences internally a lot of the frustrations and fears of being mentally ill and finds that, because this person is so successful otherwise, it is difficult, if not impossible, to have serious attention paid to the fact of the feelings and the experience of life that comes with mental illness.

The point of this person's paper is that there needs to be a way for people who seem to be making it to nonetheless have available to them some attention to their mental health issues even if they no longer present as symptoms that ought to be modifiable by some kind of medication; or, to put it another way, success in the world's general terms doesn't necessarily mean that you have a person who feels whole. Indeed, you may have a person who feels continual, not continuous but episodic, need for some attention that doesn't necessarily mean just a review of medication but may mean sitting down and saying, "So how's it going? What's it feel like? What is it we need to talk about?" If you'd keep that in mind when you read the person's paper, I would appreciate it.

I'm a clinically trained mental health chaplain. I currently serve on the Durham Advisory Committee on Homelessness. I chaired the Niagara District Health Council's plan to redevelop and redeploy mental health services in the Niagara Peninsula. So I come from a background which perhaps makes me unusually comfortable in dealing with people and mental health issues. I

also have a clinical understanding of much, but not all, of what I encounter not only among parishioners, but my church is along a route that is frequently visited by itinerant people, not necessarily homeless but frequently between one place and another. It often happens that among them there are mental health issues too, and it's sometimes difficult to know whether the mental health issues they face are largely a result of the itinerant lifestyle or whether the itinerant lifestyle is the result of the mental health issues, and how those things impact.

So I come to you with the familiarity of a clinical background of what goes on among families where adults, children and teenagers as well experience diagnosed mental health difficulties, and I also encounter the homelessness as a regular part of what I do.

That's why I thought my coming to you might be particularly useful to you, because what I'd like to stress most keenly is that from a pastoral standpoint, trying to help people find appropriate services can sometimes be very difficult. There are two primary reasons for this. One is the regulations regarding confidentiality. I understand them all; I don't argue with the need to have good systems of confidentiality. But the simple fact is that sometimes it gets in the way of providing effective help on a timely basis. It just does.

The second is that because the presumed model of mental health delivery in this area is still medical, it's sometimes very difficult to find an appropriate referral. Perhaps that's because of bias against clergy and religion or perhaps it's because of the presumption of the medical model, but again, coming to matters with a clinical background, sometimes I can hear in what people are telling me and know exactly what kind of therapist they need, and I also know of what therapeutic biases I would rather this particular person didn't have to deal with. But it's difficult to find out who possesses those biases, what kinds of treatment modalities a person will experience and what the reception will be at a given institution. I say that not because I expect a legislative committee to be able to solve that problem, but simply because I think it's useful for you to know that for somebody who is in the community system but who is not, myself, a medical provider, yet who nonetheless is expected by a considerable number of people to be able to offer some kind of intelligent help, this makes it difficult. It would be nice if there were a way for—well, you know how if you go online, it is possible to know what the expertise and the technical and academic backgrounds are of physicians and things like this? Maybe this will sound silly, but it would be nice if somebody would just write an essay on what they do and don't like in mental health patients.

It's a serious fact, for example, among GPs, that there are those who, as they set up a new practice, interview patients, and are stating quite explicitly that they are less interested in dealing with the elderly with chronic problems and even less interested in dealing with mental health patients, on the assumption that there's someplace else for them to go, and that's not necessarily true.

From my parishioners, specifically, aside from my own observations, I want to bring to you the following

things—and I want to close by offering some praise in four or five directions. One is, the least expensive treatment on an individual basis is to refer somebody to something that's paid for by OHIP. Generally, that means a psychiatrist. A psychiatrist generally means attention to medication; it's less likely to mean attention to the wholeness of the person, talk therapy, that kind of thing. What a lot of people need is the talk therapy, and they don't necessarily need to have the medications reviewed. There needs to be some kind of a way to make talk therapy more affordable to the general person, with or without regard to whether they have group health insurance or private health insurance. Getting talk therapy if you're on private health insurance is just a laugh. And by talk therapy, I mean the Ph.D. level. Yes, you have CSWs and MSWs, but not all of them are actually trained in talk therapy. OISE doesn't train a lot of people in talk therapy even if they're Ph.D.s in psychology. I think there needs to be a re-examination of the usefulness of talk therapy, and I say that coming out of 30 years of clinical background.

The second thing I'd like to bring to your attention is that there's great confusion among people who deal with suicidal loved ones. When they try to bring them into hospital to get them held for a while, when they look desperately for some assurance that the person is not going to come home tomorrow and try again, that kind of assurance is absent. Again, I've worked within the system on the wards and I understand the difficulty in interpreting and making decisions about this, but there has to be a way to help families get a better understanding immediately as to what it is they're dealing with with a loved one who has attempted suicide. If the person is going to be discharged tomorrow because, in the opinion of the psychiatrist, the person does not really represent a potential harm to himself or others, there's got to be a way to explain that. And if it isn't something the psychiatrist has time for, then maybe there's somebody else within the psychiatric system who can have that responsibility. But honestly, to listen to families who live in permanent terror about loved ones who have tried suicide is very, very difficult. While I believe profoundly in the power of prayer, it's not always adequate to people for their comfort and their assurance of the future to say, "I'm praying for you." There needs to be something more concrete to that and it needs to come from the system.

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The third is confidentiality. Again, I understand the need for it; I do. I've worked with enough abused people that I understand the reticence to let parents know about what their kids are doing and why. But you know, sometimes even people who are adult children will go into hospitals for emergencies and it's not just that the families will not be notified but when the families eventually find out and come to find their loved ones in hospital, they leave with the impression that they were really rather stupid for having expected that somebody might want to notify them that an adult child has gone

into some kind of crisis. There really needs to be more sensitivity to that. Everybody who does this stuff is intelligent. Surely there's a way to get around rigid confidentiality rules, isn't there?

The fourth has to do with bureaucratic parameters. Compassion and mercy can be overridden by catchment areas, age criteria, programs for limited varieties of diagnoses, and simple funding limitations. I run into this all the time in trying to find appropriate referrals to people: Yes, they qualify because they meet these standards but they don't qualify because they don't meet those standards. There needs to be a way to give intake clinicians a way to have more latitude. At the very least, I would like to see intake offices in our institutions required to keep track of who they turn down and why. By "who," I don't mean personal identity; I mean, what was the presenting crisis and why was that person turned down, and some information about where the person was referred to instead.

I've asked this question many times of the different helping services with which I deal, and they don't know who they turn down and they don't know what happens to them. I suggest to you that there's not a comprehensive way to understand what our mental health delivery services should be if we don't know that information.

Fifth has to do with lack of communication among institutions. CAMH does wonderful programs. So does Centenary. They don't know about each other. Nobody knows what Whitby is doing since its reincarnation. They just don't talk. And for a person who's trying to refer, because I deal with parishioners at CAMH, Whitby, Centenary and St. Mike's on a frequent basis, it's going to drive me nuts, and it's really hard on them.

I have experienced with parishioners a lack of professional understanding and tolerance of mental illness by ER staff and EMS staff. It's surprising to me. I have been with parishioners who have had to wait five or six hours at a major hospital downtown for a "psych consult," and the psych consult usually has had more to do with the medication than with the person. I know that there are efforts, particularly out of St. Mike's, to try to address that. I know they have a chair of suicidology that is providing lectures and grand rounds and things, but the people I go with are not necessarily experiencing that.

An interesting contrast: Having sat with parishioners waiting in the ER at St. Mike's—here's one of the praises—I've been absolutely astonished at the skill and carefulness with which some of the security staff at that hospital have dealt with the mentally ill whom they've encountered. It's just really astonishing to watch the gentleness and the kindness and the lack of physical aggressiveness that I've seen. I know about the stories early on. I just want to say, I've sat there; there's some good stuff that goes on.

By the same token, it's astonishing how unpreoccupied with physical security your downtown hospitals are, and again I'll point to St. Mike's. You walk into any of those doors that you get into and you're very seldom going to encounter looming, large people who

look like they're there for providing security. You know you're being watched from somewhere but it's not threatening—the second point of praise.

Back to the complaints. I was at a conference that was offered for families of loved ones who had made at least four attempts to commit suicide. I was invited along with the family at St. Mike's. One of the things I was told—we did a rotating of tables to talk with different people in the conference—one of the things that I heard most consistently from them was the frustration they experience at having to act crazy in order to get the levels of support they need when they're not quite ready to break out of the support system and on into the economy, particularly in regard to ODSP. The impression of these people was that they're being watched very carefully, and if they look like they're improving an iota, they know they're going to be tossed out of the system, and they know that their own bouts of depression are so episodic that they can't count on being able to take care of themselves next time. To have to fake an act in order to get financial support so that they can otherwise keep on improving on themselves is terribly denigrating. That's just something I've been hearing consistently.

The final one is the lack of appropriate supervised or mentored living environments for people who are okay sometimes. Again, these are folks who recognize within themselves that they'll probably never be able to be consistently independent, and they need to be able to live in an environment where somebody knows them well enough that when they watch them go out the door, they can tell the difference between the depressed state and the "I'm okay, Jack" state and can inquire, "Have you been staying on your meds? Has there been a crisis? Has there been a death in the family?"—a death will knock your wheels out from under you no matter what your mental state otherwise—and can kind of help the person reflect on whether everything that that person is planning to do for the day is really going to be adequate for the needs of living independently.

I have a parishioner in such a situation. It took me two years to get him there. He had great difficulty in other kinds of environments, and I'm just profoundly appreciative of the fact that there was anything that was willing to take him in.

The Chair (Mr. Kevin Daniel Flynn): Could you summarize, Reverend Brown? We're getting right near—

Rev. Glenn Brown: I'm on my last two compliments, okay?

The Chair (Mr. Kevin Daniel Flynn): You're doing great.

M^{me} France Gélinas: End on a positive note.

Rev. Glenn Brown: Well, yes, ending on a positive note.

I have noticed the new ACT teams; I've encountered them with two parishioners in the past year. While you'll notice in the written paper I circulated that particular person is not appreciative of ACT, I've been very impressed because I can compare it with what was going on earlier. I have found the ACT teams to be as quick and

responsive as they promise. I have found them to listen as well as one could hope as to what is really going on. The two parishioners with whom they've dealt, of whom I speak, felt that they were being taken seriously, that their needs were being regarded, and this is probably miraculous: In both cases, the ACT teams were actually able to get adequate attention from psychiatrists at the appropriate hospitals on a timely basis. That's just really, really impressive.

I guess I did do the other compliments earlier, so I'm done.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much. That was a great presentation. Unfortunately we have no time for questions, but we do appreciate your attendance here today.

Rev. Glenn Brown: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you.

GORSKI CENTRE FOR APPLIED SCIENCES

The Chair (Mr. Kevin Daniel Flynn): Our final presenter of the morning is from the Gorski Centre for Applied Sciences. Wayne and Greg, if you'd like to come forward.

Mr. Wayne Blampied: Greg will be helping me today.

The Chair (Mr. Kevin Daniel Flynn): Great. We'll give you a few seconds to get set up, then.

Mr. Wayne Blampied: I'll just start by reading the first page.

We provide web-based educational and self-awareness tools that are accessible anywhere, any time for clients as well as their support network—their family, their peers—and support workers as well. It's not treatment that we provide. What we're looking at is trying to augment treatment and to provide a continuum of care for people in mental health and addictions.

We believe very strongly in peer support. Our tools are available for peer support. We think that the educational component is what's missing from some of the peer support programs, that without consistent education there can be some misunderstanding, or some information could be misconstrued. So we're looking at a peer support education program but also with self-awareness tools, which are a way to communicate a client's well-being between himself, his peer support network and the counsellors.

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We strongly believe that what we offer is not treatment, the reason being that we believe that a trained professional needs to be involved before it can be called treatment.

The head of our company, Terry Gorski, has written 130 books on mental health, mostly focused on addiction, though. He is recognized as a leader in relapse prevention. Dr. Grinstead has a program that is focused on addiction-free pain management. We are combining the two. We're also looking at trying to integrate more mental health programs into our offering.

Again, we do not provide treatment. There are some programs online that can represent themselves as treatment. We feel that, again, if there is no professional involved, there is no treatment.

Again, because it's web-based, it's available anywhere there is computer access.

We believe in providing support, educational and self-awareness tools, not just to the client but to their peer support and especially their families. Their families are often confused, lost. They're looking for information. They may not be willing, unfortunately, in some cases, especially in addictions, to seek the help from the addiction treatment centre, but we can provide them something online so they can start understanding the disease of addiction and also look at the roles they play in the addiction and perhaps in their own behaviours towards that person that could be making it worse or causing problems within the family.

We look at expanding current programs, not changing what is already there. What is already there is working well, in our opinion, but we want to enhance it, especially in the area of pre- and post-treatment. With recovery being a five-year period at least, for addiction, and treatment being limited to one to three months, there is a large amount of time where we feel that education and self-awareness would be appropriate. So we're looking at offering this in a continuum of care.

We also look at pre- and post-treatment, especially pre-treatment, as a time in which the person is struggling. They want help, and unfortunately, they may be wait-listed and it could be weeks to months before they're actually going to make it to treatment. We see this as a golden opportunity to start the educational and self-awareness program, reducing the amount of education required then in treatment and enhancing the therapeutic content that would be available during treatment.

Again, we're looking at trying to convert wait times into an education, into an opportunity, because they really are. It is a period where these people are ready, they want help and we can bring them into, I believe, an educational and self-awareness program which would also involve peer support, which would, I think, enhance that greatly. So they're actually doing a lot before they're going into treatment.

The moment of crisis is the biggest opportunity, at least for addiction, so we're looking at offering our programs right from home, homeless shelters, hospitals, chemical withdrawal centres. Anywhere there's a crisis, if there's a computer with web access, they can access our programs and start learning, at least, about addiction.

We have mental health and addictions programs under the single, one umbrella, so we are truly concurrent.

Often in an addictions setting, a person will go in for treatment and receive some concurrent treatment, but perhaps not at the level they require. We can augment that treatment, while they're in there, with an educational process specific to the individual. So somebody with a high level of anxiety, that may be something they can actually start learning about through an educational

process and self-awareness tools, and work with their counsellor on their anxiety at the same time that they're in for addiction. The same is true for any other disorder—perhaps depression as well.

We also give the tools to the client so they're doing their own assessment. That empowers them to look at their behaviour and the results of that assessment, and by repeatedly doing the assessments over and over they start to take ownership of the results of those assessments and start taking ownership for their treatment, and they start looking at it differently. Rather than, "Fix me," they start to take the attitude of, "I want to be fixed. How can you help me?" Then they start looking out through these programs, because we have a myriad of programs. We're looking at eventually having 60 small programs so that they can actually go shopping and augment their own treatment. The core treatment would remain the same, but they could get their special needs met.

The self-awareness program is based on cognitive behavioural therapy. By having them ask themselves the same questions over and over again, they start breaking through their denial and start seeing the reality, but they also take ownership. The most powerful question we had in one of the inventories was, "Are you an addict?" Most people would put a number from zero to 10. When that number was written down and they had to put the number in and click it down, they took ownership of that number. The same with anxiety: We found that people who would answer the question, "I can manage my own anxiety," or "I can do things to manage my own anxiety," when they put a number beside that, they took ownership. So we're looking at trying to put the client in charge of their own treatment and, through the use of this tool, integrate it to the existing services.

Our programs are extremely extensive. We want a client to be able to come to us and be able to pick up everything they need, but also, if they realize that their needs are beyond what this tool can do, because education and self-awareness is only going to help somebody with a mild problem, it's going to empower them to look for solutions. If there is a problem that is beyond what education and self-awareness can do, then there will be a way to get further treatment through recognized treatment centres that already exist.

We would love to provide early intervention programs on addiction education. I think this is where education could be the most powerful, in schools. When someone gets in trouble with drugs or alcohol or behavioural problems, an educational intervention could be the first phase, and a self-awareness process.

Also family programs: Many of the families struggle with a lack of knowledge around their children's behaviours, their children's addictions. They suffer almost as much as the person themselves, sometimes more, because the child, especially an addict, is medicated. The parents aren't medicated, and if we can educate them and bring them into the understanding, they can start doing things to protect themselves but also to understand what's going on.

Judicial programs: We believe that our programs could be used in court diversion. Some of our programs are in line with programs that are being used in California right now. Rather than have people doing community work, they could possibly be instructed to take an addiction education program in a supervised site and have to graduate from that as part of a judicial program, perhaps.

We'd like to see this available through community centres, Ontario Works centres, children's aid societies, as well as shelters. We have talked with the Salvation Army about perhaps putting it into Gateway, so that would at least be available to people who are homeless so they can start the educational process.

There are many programs I think that this could actually be integrated with, and the education will become the forefront of the process.

Our programs are written at a grade 5 level. We anticipate a lot of cognitive difficulties. Generally most content on the Internet is written at a grade 5 level, so we've simplified the programs. Some of the programs we evaluated, it would take a college level to understand them, and that's not going to help our people.

We can also translate into other languages. Of course, we would love to be able to adapt it appropriately to different cultures within Canada.

We provide remote education and self-awareness. Along with some of the tools that are available now—online counselling, for instance—treatment could be provided into the most remote areas of Ontario. We extend the reach of existing services. Quite often, somebody will go to a very good treatment centre, spend three months there and then leave and have to go home, miles and miles away, and they've kind of lost contact. With this tool, by taking it before treatment, during treatment and then taking it home with them, they feel like they're still connected. Especially through the self-awareness inventories, they could be remotely monitored by their counsellors to see if they're at risk of relapse. By their completing the self-awareness inventories on a daily basis, those inventories can be used to determine the wellness of the person who has completed treatment for an extended period after treatment and proactively call them back in, if need be.

We're writing programs currently for the military, so we adapted their motto: Leave no one behind. The military program we're developing is based on "train the trainer," where we're going to go through, and everyone in the military will be taking the post-traumatic stress disorder program. It destigmatizes because everyone has to take it. At the same time, once we get one class through, that class will take the next class through. We've developed a program that is very easy to run. They can take it with a limited amount of background. Then the self-awareness inventories will be monitored by the counselling services in the military to determine if further action is appropriate. If not, then the peer support will be effective enough.

I have a few more minutes, I guess?

The Chair (Mr. Kevin Daniel Flynn): You have about two minutes.

Mr. Wayne Blampied: Are there any questions?

The Chair (Mr. Kevin Daniel Flynn): Perfect. I think we were going to start with this side first. Christine or Sylvia? We probably have time for one question.

Mrs. Christine Elliott: You were talking about the possibility for remote learning. I was wondering if you have any programs operating right now in northern Ontario, in any of the fly-in communities, for example.

Mr. Wayne Blampied: We had a program running for a few months, a very small trial, in South Cochrane Addictions Services. We've had our first graduate, who did very well. Actually, the results were forwarded to the Ministry of Transportation and her licence has been renewed. What they like about it is the flexibility—this is a working woman who has a family—to be able to take it during their own time.

Mrs. Christine Elliott: Is that a contractual arrangement, then, through the federal government?

Mr. Wayne Blampied: No, it wasn't. It was a free trial we offered to her, so there was no responsibility on the ministry to accept it, but they did accept it.

Mrs. Christine Elliott: Thank you.

The Chair (Mr. Kevin Daniel Flynn): We have about a minute left. France, did you have a question?

M^{me} France Gélinas: Yes. I'm just curious to see, right now, how do people gain access to your program? How does it work?

Mr. Wayne Blampied: Actually, people are sent an activation code, and then they set up an anonymous ID. So the whole system is anonymous. We don't know who is who. The only person who will know who that client is is their counsellor or perhaps their peer support worker. It's sent through e-mail, they activate the account and then they simply log on. There is no software that they have to download or anything like that.

M^{me} France Gélinas: I come from northern Ontario, and I'm guessing that you need high-speed Internet.

Mr. Wayne Blampied: It does work on dial-up, but it's relatively slow and a lot of people have not been happy with it, honestly.

M^{me} France Gélinas: Who pays for the service?

Mr. Wayne Blampied: Currently, we're looking at a subscription to the individual, the client themselves.

M^{me} France Gélinas: And what is the price?

Mr. Wayne Blampied: Currently, we're running at around \$50 a year.

M^{me} France Gélinas: To subscribe? And if they're being followed by a counsellor, then the counsellor has access to their account?

Mr. Wayne Blampied: What happens is, the counsellor has to contact us and we have to get something in writing from the client allowing the counsellor access. Then we will grant the counsellor access.

M^{me} France Gélinas: Okay. Where do your clients come from, mainly?

Mr. Wayne Blampied: A lot of them are people who are in recovery already who realize that they've come in through a 12-step fellowship and they never got the educational process. The other area is referrals through

counsellors that we've been in contact with. We have some down in California who are ex-offenders, and it's part of their parole program. So a variety of referrals, actually.

M^{me} France Gélinas: And has it been translated into French already?

Mr. Wayne Blampied: No, it has not. We're still under development. French will be our next language.

M^{me} France Gélinas: And you offer your services in the States?

Mr. Wayne Blampied: Yes, as well as in Britain.

M^{me} France Gélinas: As well as where?

Mr. Wayne Blampied: In Britain. Right now our major focus is the military, and that will support the affordability for the addiction treatment providers, because we know that funds are rather limited in the market.

The Chair (Mr. Kevin Daniel Flynn): Our time is up. Thank you very much for your presentation. Thanks for coming today.

We're recessed until 1 o'clock. Enjoy your lunch.

The committee recessed from 1154 to 1302.

GARY ROBINSON

The Chair (Mr. Kevin Daniel Flynn): Okay, let's call to order. Thank you very much, those people who are waiting for us to get going.

Our first speaker of the afternoon is Gary Robinson. Gary, if you'd like to come forward. You have a choice of seats. If you want to grab some water, I'll go over the rules for the benefit of those other people who perhaps are in the audience and who will be speaking later.

Everyone has been assigned 15 minutes. You can use that any way you see fit. If you want to leave a little bit of time at the end for any sort of a discussion, question and answer, that would be good too. Other than that, it's all yours. Have a seat; make yourself comfortable.

Mr. Gary Robinson: Good afternoon, and thanks for taking your time to spend with me. It's an honour to be in a room with such luminaries.

My name is Gary Robinson. I struggle with severe mental health challenges. I've been involved with the mental health system for over 35 years. I'm considered a consumer-survivor and have recovered from my illnesses. I believe I'm a consumer surviving, and not recovered but recovering from them.

I must admit I'm the exception, not the rule. I take my medication, which of course is the golden rule. I take handfuls of medication. I have a phenomenal support system, meaningful relationships and meaningful activities.

That's not to say it's been without a lot of struggle. I've had very dark days in my life. I've had physicians who were detrimental to my well-being. I have been poked and prodded, and I have tried wild cures and medications with horrible side effects. I do get admitted to hospital once or twice a year, and I kind of feel, well,

you've got to make hay while the sun shines so you do your best in those times out of hospital.

I'm a firm believer in first-episode psychosis interventions and, in particular, peer support. I would have benefited tremendously from those interventions.

That's all I have scripted.

Wait times in a hospital's emergency room: awful. Not the time you spend before you see the crisis nurse—because you have to be medically cleared by a doctor before you can see the crisis nurse, and the crisis nurse will then speak to the psychiatrist on call. But when you're put in a cell—that's the only way I can describe it—it can make you, pardon the expression, go nuts even more. A camera's staring at you sitting in one chair in a room the size of anybody's bathroom. It's intimidating, and some people cannot handle it. Then it becomes an issue and they have a violent patient on their hands. That's one thing.

I don't believe you should be—how can I put this? I think you need to be supported when you walk into that emergency room. I think you need peer support, someone who can say, "I've been there, done it; I know what you're going to go through."

It breaks my heart to see 19-year-olds being escorted up to the psych ward, because I was them. Like, by the grace of God go I.

Every mental illness is very particular and unique to each person, so you can't really put people in pigeonholes. You can't use a tool to decide what this person is going to do or benefit from or whatever.

As you probably know, medications are only a treatment; they're not a cure. There's no blood test to determine which medication is going to work for you. No one can say. It takes years.

I've been extremely fortunate. I'm married; I have two great kids. They've been the best support I've ever had. I consider myself extremely—well, it's a dream come true for me, because there was a time when I thought I wouldn't make it past the age of 21. My teenage years were a total washout. It was a time when no one talked about mental illness. I missed most of high school but, thankfully, graduated from high school.

Stigma? Huge, because when you see a person, you see how they are around you, how they react to you. No one knows what's going on inside someone else's head. Sure, you can have experience as a doctor or psychiatric nurse that, "Okay, this is generally what happens," but it is so individual. Nurses in the ER—just horrible things they say. Because I work in the hospital that I spend time in once or twice a year, it's rather difficult for me, but that's where I got my start.

At any rate, as I say, I am the exception. I believe in peer support wholeheartedly. I think, for myself, I have so much to offer. It just hasn't been coming to me, so to speak.

My medication is extremely expensive. Hospital stays, as you know, cost thousands of dollars a day.

The ACT model is a good model. It's expensive, I know. It's sort of like, as you probably know, a hospital without walls. That's a very popular thing to say.

I know people from 30 years ago, when I was in the system earlier, who haven't changed at all. They still have concurrent disorders that beat alcohol or drug abuse. That is something I can't speak to. I've never had any experience with addiction or concurrent disorders.

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But one thing that I did have, and that I think has carried me through, is hope. I know I'll get better after that stay in the hospital. I know I'll get out of the doldrums. I know that things will get better. But I've been through a lot, and I think the opportunity to speak here is phenomenal. I just speak for myself. I don't have any charts or graphs, I don't have statistics, I don't have models, I don't have anything like that. I just wanted to come here to let you know that things do need to change, definitely—the budget's always a problem or an issue—but I think things can be done with early episode psychosis. I was 15 when I was diagnosed and nobody knew what was going on. They really didn't. I said and did and thought awful, awful things.

I'd like you to ask questions, actually, so have I got time for questions?

The Chair (Mr. Kevin Daniel Flynn): The time is yours.

Mr. Gary Robinson: Thank you again for listening to me and I hope we have time for questions. That's me.

The Chair (Mr. Kevin Daniel Flynn): You've left a lot of time for questions. I forget where we left off. Why don't you start, France?

M^{me} France Gélinas: Thank you for coming, Mr. Robinson. If you feel the questions are too personal, feel free to say, "I don't want to share this," and we'll move on. The first one is, you mentioned that you'd like early episode, first episode intervention—I forgot how you called it.

Mr. Gary Robinson: Psychosis.

M^{me} France Gélinas: Yes. What is it in this program that you like?

Mr. Gary Robinson: Early intervention psychosis: If you have someone like myself, who hasn't had any treatment—because you don't know what to do. You haven't had any treatment, you haven't had any experience, so you tend to lift away, become accustomed, if you're psychotic—you kind of do that—and you will pick up mannerisms and things, especially for parents who don't know what they're going through. So first episode psychosis is to catch these people and their families and support them, and it has been proven. Early episode psychosis programs are popping up all over the place. It's where you nip it in the bud, so to speak.

M^{me} France Gélinas: Okay. You mentioned that you have to take a lot of medication and it's very expensive. Who pays for your medication?

Mr. Gary Robinson: My insurance company through work.

M^{me} France Gélinas: You have private insurance?

Mr. Gary Robinson: Mm-hmm. And that's another thing: I know these insurance companies say that they

don't have a lot of money, but I've cost Sun Life quite a few dollars.

M^{me} France Gélinas: It's what they're there for, I guess.

You talked about some of your personal experience when you needed to go to the emergency room, and the wait and the environment in which you had to wait. Is there a better place to access the health care system than the emergency room? Or is the emergency room where it should be, just in a different environment within it?

Mr. Gary Robinson: For me, I go to a medication clinic once a month to get refills on my scripts, but maybe that's a good place for the psychiatrists—just a clinic atmosphere, just a drop-in kind of thing. I think you can keep tabs on people. They've got a community support team. I've never been involved in that, but they keep a close eye on people. I, because of my experience, know when I need to be in hospital. As I say, the support network includes everyone from my wife, my kids, my friends, my doctor—

M^{me} France Gélinas: But you're at the point where you know that you need more help than you can get at home, that you need hospitalization. There's no way for you to get admitted without going through an ER?

Mr. Gary Robinson: I haven't—

M^{me} France Gélinas: That's the way the system works, so that's—

Mr. Gary Robinson: They prefer you to see the psychiatrist, and hopefully he can assess you over a couple of weeks and say, "Look, Gary, you need to be in," but—

The Chair (Mr. Kevin Daniel Flynn): Okay. Let's move on to the next questions. Maybe you can answer that at the same time. Liz?

Mrs. Liz Sandals: Actually, I wanted to follow up with your comments on peer support, because you talked about the value of peer support and getting support and understanding from someone who's already been through it. How would you organize that? How would you manage linking someone like yourself up with someone who is having a first episode or needs some understanding?

Mr. Gary Robinson: I think the Canadian Mental Health Association in Oakville does some of that, and the society for schizophrenics. I have personal experience with being a mentor, if you want, to a young man who was very ill. I don't want to blow my horn, but now he's in third year law at Queen's, and he has said many times that I saved his life. Obviously I don't believe that, but that's what he says. We're still in contact. I just met with him again last week. Just the fact that you can say, "I've been there. I know it," says more than an education. Statistics say that a peer can connect with a mentee, if you will, more so than it would take six months for a doctor or a nurse to do the same. Just to be able to say, "You're not alone," that's the biggest thing, because mental health is still a stigma. Unfortunately, the people who care for you probably have the biggest stigma.

I've heard and read some of the transcripts from these meetings and I see a lot of people complaining—no, I shouldn't say that; that's not right. It's a lot of people struggling and butting heads and not getting this and not getting that. I think you have to co-operate with the system to get anything out of it. People who don't take their medications—well, I'm sorry, but taking the medications is going to help no matter how bad the side effects are. But you've got to get the person to take their meds—

Mrs. Liz Sandals: And that's maybe something that you can help people understand, what are wise courses of action or not from the perspective of someone who has been through the experience.

Thank you very much for coming and sharing your story with us today.

Mr. Gary Robinson: Thank you very much.

The Chair (Mr. Kevin Daniel Flynn): Sylvia.

Ms. Sylvia Jones: Mr. Robinson, thanks for appearing. I wanted to go back to your—you mentioned that you were diagnosed at 15. So I'm assuming there were some family supports at that stage.

Mr. Gary Robinson: No.

Ms. Sylvia Jones: Okay.

Mr. Gary Robinson: My parents had no idea what was going on. They never had any experience with mental health in my extended family.

Ms. Sylvia Jones: Were you living with your family at the time?

Mr. Gary Robinson: Yeah.

Ms. Sylvia Jones: The reason I'm asking is, we've had a couple of presenters talk about the challenges that they were dealing with with privacy issues. I'm wondering if that ever came up in your—

Mr. Gary Robinson: Well, it depends what you want it to be when you talk about privacy. At work and in my general experiences in life, it's not a secret that I have a mental challenge, but no, I don't—

Ms. Sylvia Jones: I'm thinking more in terms of your family being included in the diagnosis treatment plan, any of that.

Mr. Gary Robinson: They weren't, not at all. And it caused some rifts in my family, for sure.

Ms. Sylvia Jones: Okay. Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today. I know we've spoken before.

Mr. Gary Robinson: Yeah, at your constituency office.

The Chair (Mr. Kevin Daniel Flynn): That's right. I knew your story and I was trying to think where we talked before now.

Mr. Gary Robinson: That's right. Thank you all very much.

The Chair (Mr. Kevin Daniel Flynn): Thank you.

Mr. Gary Robinson: Is it okay if I sit and listen?

The Chair (Mr. Kevin Daniel Flynn): You spend all the time you want. We're staying till 4. You can stay as long as you want.

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416 COMMUNITY SUPPORT FOR WOMEN

The Chair (Mr. Kevin Daniel Flynn): Our next presenters this afternoon are from the 416 Community Support for Women group. We've got Rosie Smythe, Alex Branston and Rajini Potechin. If you'd like to come forward and make yourselves comfortable. There are a number of microphones there.

Ms. Rosie Smythe: Thanks so much for having us today.

The Chair (Mr. Kevin Daniel Flynn): No problem at all. Make yourself comfortable.

Ms. Rosie Smythe: Okay, I guess I'll get started. My name is Rosie Smythe, and I have with me Alex and Rajini. Alex and I work at 416 Community Support for Women. It's a daytime shelter for women in Regent Park. Rajini is a medical student from St. Mike's hospital and she did a study with our women. It looked at their level of satisfaction with medical services, both in our agency and outside. Alex talked to many women who come to our centre just to get a voice of theirs here today and to get their suggestions, so she'll talk to you about that.

In order to give you some context, I'll briefly tell you what we do at 416. We offer an array of services to marginalized women dealing with mental health and addiction problems. We offer breakfast and lunch for up to 100 women a day. We have showers, laundry facilities and a weekly food bank. Most of our women live in the area and they are aging; most of the women are over 45. Our staff help the women manage their money, and we run an ID clinic.

We also happen to have a medical component, which includes two family physicians. They run clinics twice a week in our centre. We have a registered nurse on staff. We offer one-to-one mental health and addiction counseling as well. We do this all in partnership with numerous community agencies and services.

That's just very brief. I didn't want to take too much time to go over our services, but I think you have a bit of an understanding there of what we do.

Our women are pretty marginalized and aren't women who usually get to have their voices heard, and that's what we wanted to do today: bring forward some of their thoughts. Alex, did you want to talk about what you found out?

Ms. Alex Branston: Our clients like the idea of accessing walk-in clinics; then they don't have to go to the ER. They like having medical staff in the drop-ins in the community. They'd like to receive more respect and compassion from health care professionals. They would like to be treated with dignity and understanding.

Some women suggested that the system needs to be sure there are advocates for vulnerable individuals. They feel that they are being treated unfairly due to their housing status. One woman asked for equal access to service: They feel that they are waiting too long for services with lengthy wait lists. This woman was actually talking about

having to wait 90 days to get into an addiction treatment program.

I'd like to now read some quotes that I took in talking with some of our women:

"When you are poor and a woman, the medical system often considers mental health before health issues." That is, health care staff often see a poor, dishevelled woman and assume she's there because of her mental health issues instead of medical issues.

"I just lost my husband three months ago from cancer. We had to wait five to six weeks to get him a bed on a palliative care unit. The staff were very kind to me and my husband. But it seems ridiculous to have to wait so long just to go somewhere to die."

"I like that 416 offers a psychiatrist, a foot doctor, two medical doctors and a nurse. It makes me feel the same as everyone else and that we are being treated equally."

"I live alone and sometimes I have really horrible anxiety attacks. I don't want to go to Gerstein or the hospital. It would be nice to have more mobile crisis teams that could come to my apartment and help me through my anxiety."

"I feel that we had a better health care service 10 years ago, but due to budget cuts our health care service has declined."

"I like that I can connect with addiction counsellors who will support me before going into treatment, help me get into treatment and then work with me when I've finished treatment."

"I went to the ER once and was treated like dirt. I think it's because they thought I was homeless."

"I have hep C stage 2. I need treatment, but cannot receive treatment until it's at stage 3 hep C. What are you supposed to do, just wait until it gets worse?"

"I think because I'm homeless and living in a shelter, it makes people think they can treat me like garbage because I don't look that good."

"I want to get clean, but waiting to get a bed at a withdrawal management centre is hard. I can't stay clean long enough."

"I have been given five different mental health diagnoses from different doctors over the years. Everyone wants to give me new meds to try. Thank God, I am covered by ODSP or else I wouldn't be able to have the medication. But I still don't know which doctor was right about my diagnoses."

I'd like to turn it over to Rajini.

Ms. Rajini Potechin: While I was at 416, I really wanted to understand the advantages of providing a regular source of care to homeless women within the centres like they do, because it's been found previously that this will result in less unmet health care needs. These women are more likely to seek preventive health care services, and more likely to express satisfaction. In my mind, these were particularly important in these cases because there were mental health and addiction concerns.

My research question was comparing the satisfaction and accessibility associated with health care services

within and external to the 416 drop-in centre. My population was homeless adult women.

I had a small sample size and interviewed 17 women. I measured satisfaction with care using the homeless—a satisfaction-with-care scale—and accessibility by asking questions such as, "How many times have you used these services in the past? Would you use it in the future if you had concerns?" I compared the services that Rosie mentioned that are within the centre to their responses with the services outside, including hospital visits, outpatient visits, ER visits and government-funded home care.

I wasn't expecting a statistically significant difference because of the small sample size. There was greater accessibility—again, not statistically significant. But I was very surprised to see that there was enormous difference in the satisfaction and that this was significant despite the extremely small sample size.

The scale is broken up into various themes, and this is particularly seen in themes such as trust, as in they trusted their provider and felt the provider trusted them; inclusionary care—there were fewer barriers to them in accessing the care; respect; and assumption-free care.

I then wanted to understand a little bit more about what's worked for 416 and why the clients are so much more satisfied with this care. I think there are two big reasons. One is, as I mentioned, that barriers were broken: The medical clinic is on-site; there is an ID clinic there, which is a big barrier—often these women lose their ID or it's stolen; the clinic offers flexible schedules, so the women can come at any time within the time frame that the doctors are there; blood work is done on-site; for prescriptions, the costs are covered and the staff will pick them up and hold on to them, so the barriers with mental illness that are involved with drugs are eliminated as well; and there are escorts for hospital and clinic visits.

The other big reason is that it fits into this multiple-access care. This overlaps with the barrier reason because there are often daily pressures that take priority for this population. So the centre helps clients cope with their symptoms and solve their practical daily problems by teaching cooking and offering laundry services. The centre also has interventions to help their clients' social environment, such as helping them solve their housing problems and helping them with money management.

I think these are a big part of the reasons why these women find these services much more accessible and are much more satisfied with them.

The other thing that I think is important with this population is to encourage these individuals to vocalize their concerns and feel like a part of the process.

I think that's all from me.

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Ms. Rosie Smythe: We just wanted to finish with some suggestions and, as staff who work at 416, we have a few points we want to present.

The first one is that we wanted to suggest that the system look at securing affordable and supportive housing. This is essential for this group. Without this, they

really don't have a chance to overcome their addictions and/or their mental health problems.

Ms. Alex Branston: I had a client who I was referring to treatment. She desperately wanted to get clean. She was homeless and living at Fred Victor, but due to her housing status, she had a terrible time following through with the pre-treatment requirements and, ultimately, sobriety.

Ms. Rosie Smythe: For our women who are housed, most live in terrible conditions in city-owned buildings with all sorts of other people dealing with mental health and addiction problems. This can make it very difficult for them to remain sober following treatment, or to even maintain a goal of harm reduction. They need safe, clean housing, dispersed throughout the city.

It was reported in the Star on September 1 that the Dundas-Sherbourne corridor, where 416 is located, ranks number one in the city for violent offences. It makes it a very unsafe environment for our women to live in.

I'd also like to suggest that hospitals and community agencies really need to collaborate in order to provide holistic supports and services to people. As a community agency, we have put effort into trying to form partnerships and alliances with hospitals, but it has proven somewhat difficult. I think community agencies work fairly well together, but it would make the system more streamlined if efforts were put into promoting and supporting collaboration between hospitals and community organizations.

Ms. Alex Branston: We would like to suggest the importance of including front-line staff in the planning of the future health care system. We are the people dealing directly with the clients, and therefore feel that we are in a better position of creating dialogue with consumers about their needs from the health care system.

Now, 416 is fortunate enough to have medical services for our clients and other local individuals on-site. This allows our clients to have regular contact with a family physician, no matter what their housing status is. We would like to suggest that you provide leadership in setting up this type of model of multiple access points in the community. We feel that this would provide for a more coordinated system.

Ms. Rosie Smythe: We feel strongly and want to urge you to put forward an effort and/or funding into educating the general population regarding addictions and mental health. Our clients continue to be subjected to discrimination, including the criminalization of their behaviours associated with these disorders.

Ms. Alex Branston: We would also like to suggest that you invest in a mental health and addiction promotion approach to strengthen public perception that freedom from addiction and mental health are integral to their overall health. We certainly work hard at putting this forth in the work that we do, but think that a government effort would be worthwhile as well.

Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much. You've left, I think, time probably for one question. Somebody from the government side: Helena?

Ms. Helena Jaczek: Thank you. Well, you've certainly showed us—we've heard quite a bit about multiple access points, depending on the population, and obviously you are fulfilling a real need for the women that you're looking after.

Are you funded by any particular government ministry? Were you a pilot project? How did you get started?

Ms. Rosie Smythe: The agency was started 25 years ago by a woman named Joy Reid. She was the founder. She was able to access salary dollars, so all of our staff are funded through the Ministry of Health, through the LHIN. But our operating funds we get through fundraising, and it's a really difficult task for us. It's not easy because women with mental health and addiction problems are often very misunderstood and not really a favourite charity. It's a very specific person with a background and understanding about addictions and mental health who has been able to help us.

Ms. Helena Jaczek: And are the physicians billing OHIP?

Ms. Rosie Smythe: Initially, the physicians came in and they actually ran these clinics for free. They weren't paid. Now they can get paid through an inner-city fund through—I think it's the city of Toronto which has set this up, so if any inner-city doctor is connected with a hospital and runs these clinics, now they can get paid. But it's a more recent thing. Also, in terms of the medications we talked about, the doctors donate money for our clients to get medications. For most of them, that's where the money comes from.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today. Excellent presentation. Thanks for taking the time.

Ms. Rosie Smythe: Thanks so much.

The Chair (Mr. Kevin Daniel Flynn): Our next presenter this morning is from—

Ms. Silvia Kendall: May I just approach for a minute? I just want to say that this group here is amazing and they show within their program the nurturing that is needed. I would also like to mention that it's not just for women. It's for the men out there as well.

The Chair (Mr. Kevin Daniel Flynn): Thank you.

Ms. Silvia Kendall: And I thank you for your time.

DAVID HEATH

The Chair (Mr. Kevin Daniel Flynn): Our next presenter is Dr. David Heath. Dr. Heath, if you'd like to come forward and get comfortable. There should still be some clean glasses there if you need any water or anything. I think you were here at the start when I was talking with Gary and was saying everybody gets 15 minutes and you may use that any way you see fit.

Dr. David Heath: Good afternoon, ladies and gentlemen. Thanks for the opportunity to present my ideas. Believe it or not, this is the first time, after knocking on the doors of the provincial and federal governments, I've been able to talk to anybody about what I'm talking about today.

My name is David Heath and I'm a psychiatrist in the Waterloo region. I'm going to talk for 10 minutes and leave five minutes for questions. I did have a previously written submission which I trust you all have. I also brought some other material which I think Ms. Sourial has distributed. You don't need to look at it. It's background except for the top two figures of the material I brought today. I'm going to be referring to those, so I hope you have those.

My submission relates to number two of your terms of reference, which is to explore innovative approaches to delivering services in the community. In particular, I'm going to focus on a service that's an alternative to hospital admission, and the innovative approach I will talk about is what I call mobile crisis home treatment.

Today, I want to leave you all with one idea: The Ontario mental health system needs to develop a community-based alternative to the practice of admitting patients to a hospital psychiatric ward when they are in a crisis. This would be best accomplished by short-term, intensive treatment in the patient's own home. By "home," I mean their home, but it also includes temporary homes. We've treated homeless people in shelters very successfully. This short-term, intensive treatment is mobile crisis home treatment. For short, today I'll just call it home treatment.

My credentials today for talking to you about this are two. One is, I started the first home treatment service in Canada 20 years ago this fall in Kitchener at Grand River Hospital. Secondly, I wrote the first book on home treatment, called *Home Treatment for Acute Mental Disorders: An Alternative to Hospitalization*. This was published by Routledge in New York in 2005. I've left you with some information about the book. Now, I'm certainly not here to try to sell you folks my book, but I do get asked about it. Also, quite frankly, I hope it adds some credibility—the book and the reviews—to what I'm talking to you about today, which is why I gave you the information.

So why do we need an alternative to hospitalization? The reasons fall into four broad groups.

The cost of hospitalization: Mental disorders are no slouch when it comes to driving up hospital costs. If you look at table 1—this is from the Canadian Institute for Health Information, CIHI; the 2004-05 figures. Of the 15 medical conditions, not just psychiatric, that cost the most in a year to treat in hospital, mood disorders ranked number 6 out of 15. Schizophrenia and delusional disorders ranked number 12.

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Table 2 comes at it a different way. It divides expenditures into what are called clinical chapters. This means groups of diseases of each organ system, like respiratory diseases etc. You can see that of the 20 chapters, mental and behavioural disorders ranked sixth out of 20.

The second group of reasons is patient and family preference. My experience and studies indicate that most people prefer to keep their normal life on the go as much as possible, even when they're in a crisis. You've likely

been hearing about the influence of the recovery movement on mental health services in this committee, and avoiding hospital is consistent with those principles.

The third group of reasons is that hospital is just not a good fit for numerous groups of patients. These are many. They include recent immigrants who don't speak English, senior citizens, mothers who've just had a baby and have a postpartum disorder, first episode psychosis, as mentioned by the previous speaker. Some patients, like those with borderline personality disorders, actually get clinically worse in hospital. At the other end of the spectrum, local doctors, nurses and VIPS like yourselves often feel acutely uncomfortable on a psychiatric ward.

Fourthly, in some parts of Ontario there are insufficient beds. The last page is a comparison of the Ontario recommended ratio of beds to various cities in the world.

How does home treatment work? There's a patient in crisis in a psychiatrist's office, a family doctor's office, an emergency room or a mental health clinic. The clinician considers that they need hospitalization. Normal procedure, as we've heard discussed earlier, is to send them to the ER. Sometimes you can bypass that by calling the psychiatrist on call to arrange admission.

With home treatment, a proportion of those patients—and I'll say how much later—can be diverted to home treatment and bypass the ER. The same clinician, instead of phoning the ER, phones the home treatment team, who will go to the patient's home that day or the next day, depending on circumstances. The team sends a worker or two workers who visit daily. They can even visit up to three times a day if necessary. That's very rarely needed. There's some kind of 24-hour emergency coverage supplied and psychiatrists regularly make home visits. Psychiatry is not high-tech, so any treatment you can get on a psychiatric ward you can get at home, except for locked doors, physical restraint and close observation.

The treatment in home treatment is the same as hospital. It's usually a combination of medication, practical help with the many social problems that these patients have, and counselling. There's a very large emphasis on recruiting the natural supports of the patient. There's a huge emphasis on working with families. They don't need to live with the patient and the natural supports can include other people such as friends, college roommates, neighbours, a landlord. Length of stay varies. Four weeks is common, but it can be shorter or longer.

Home treatment can also be used to drastically shorten hospitalization. Let's face it, many times you cannot avoid hospitalizing a patient, but some patients settle down after just one or two days on the psychiatric ward, settle down enough to be transferred to home treatment.

What about the research evidence for home treatment? There are about 14 studies over 40 years in five countries on four continents—the last one, and the best one, was in 2005—all showing the same thing: that about 37% to 50% of patients destined for hospital can be treated in home treatment. The results are the same in terms of symptoms, functioning, risk of suicide, harm to others. Usually patients and families prefer this, and it's about

40% cheaper. Some cases of involuntary hospital admission can be avoided. Just because you refuse to go to hospital doesn't mean you can't be persuaded by a skilled professional to accept treatment in your own home.

What's the international experience with home treatment? Australia was the first to adopt this nationwide in the late 1990s, mainly in the states of New South Wales and Victoria, where it's part of the routine mental health system.

England is unique, though. I have never seen this with any other model of treatment, in which a country decrees, as the English did in 2001, that there should be nationwide adoption of this home treatment model, where it's called crisis resolution teams. They decreed that there should be 335 services created throughout Britain—there were already some services leading up to that—with an expected 30% reduction of pressure on hospital. Since then, naturalistic studies have shown reduction of admission in the northeast of Britain—Yorkshire, Newcastle region and Birmingham—of 37%, 45% and 50%. Some wards have been closed.

So how about Canada? There are four home treatment services in Canada. To my great surprise, when I read the Romanow report on the future of health care in Canada—I don't know if you're familiar with that, the federal Romanow report, from 2002—there was a highly specific mention of home treatment. There was no reference, and I've not been able to speak anybody in the federal government as to how it got there or what they want to do with it. It doesn't seem to have had any influence.

There are four services. The first one is called the Hazelglen Service, at Grand River Hospital in Kitchener, established by myself in 1989. Then we opened a branch in Cambridge across the 401 in 1998; in 1993, at the University of Alberta Hospital in Edmonton; and in 2001, at the Royal Jubilee Hospital in Victoria. In 2006, the Fraser Health Authority in the communities of Langley and White Rock/South Surrey had two pilot programs. They've been using my book for their steering committee and staff, and I included an e-mail from those people.

In conclusion, I'm suggesting that the Ministry of Health adopt a policy in which clinicians are encouraged to avoid thinking of hospital automatically when faced with a patient in a crisis, and instead consider whether the patient before them can be treated in the community, and that home treatment be the principal model to use. They should take a leaf out of Fraser Health's book, start two or three pilot studies, one in a rural area, one in a medium-sized town or one in Toronto, relate it to one of the terms of reference, leverage—I think it may be possible to leverage some of the mobile crisis teams in the province, which are quite different, into home treatment teams, where they would be more useful.

I have some time for questions.

The Chair (Mr. Kevin Daniel Flynn): Thank you. I'm going to start with one. I haven't asked a question all day today, so I'm going to start with one question.

Dr. David Heath: Okay.

The Chair (Mr. Kevin Daniel Flynn): When the committee was in Kingston, I think we heard from the

former chief of psychiatry at Kingston General Hospital and he said that everybody talks about a shortage of psychiatrists in the community. He used his own city as an example. He said, "In the city of Kingston, we've got over 40 psychiatrists, but less than 10 of them will see patients." The other 30 of them are doing research work at Queen's, presumably. If it's hard enough to get psychiatrists to see patients in the first place, how could you convince a psychiatrist to get into what I understand you're proposing, which is sort of a mobile method of treatment, if they won't even see people in their own offices these days?

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Dr. David Heath: As I say, our program and the one in Cambridge—our program has been there 20 years. We've had no trouble getting psychiatrists. I'm semi-retired, so we've been able to find other psychiatrists. You have to pay them sessional money; you can't just bill OHIP, because there is a lot of non-face-to-face work. So there has to be adequate sessional money or a salary. Fee-for-service will not fly, but you can combine it, which is what they do in Kitchener.

The Chair (Mr. Kevin Daniel Flynn): Okay, the idea sounds great. The idea sounds wonderful.

Dr. David Heath: And it's actually very fascinating work. If you provide them with an adequate team and a rationale, I think you can get them to do that.

The Chair (Mr. Kevin Daniel Flynn): Wonderful.

Let's go on to either Christine or Sylvia. Do you have questions? We've got time for probably two questions.

Ms. Sylvia Jones: Just to follow up with what the Chair was referencing, with your program in Cambridge, have you been doing sessional money through OHIP or how are you doing—

Dr. David Heath: Both, for 18 years: sessional money plus OHIP.

Ms. Sylvia Jones: And that was a special arrangement that you were able to work out with OHIP when you set up?

Dr. David Heath: Oh, no. Most psychiatrists now who work in hospitals get what's called sessional money for the non-OHIP work they do. There's nothing unusual about that; it's been there for years. It's no different.

Ms. Sylvia Jones: Thank you.

The Chair (Mr. Kevin Daniel Flynn): France?

M^{me} France Gélinas: I saw that Hazelglen has been evaluated, and certainly with flying colours in the review. Were you involved with this review? I was curious to see how many patients had been evaluated to give—

Dr. David Heath: It wasn't an academic—the hospital had a program evaluator and she evaluated it. The people you treat, would they really end up in hospital if you weren't there? You never really know. So we measured how sick they were, and there's a measurement where you can compare your patients with patients in a psychiatric hospital in the US, a famous one, McLean Hospital. So 85% of our patients scored severe; 61% of McLean Hospital in-patients scored severe. It was a high

level of improvement and satisfaction. There was that kind of evaluation.

M^{me} France Gélinas: So when you were first setting up, and I guess even to this day—how does the primary physician in his or her office decide they are a candidate for the at-home service versus no, they really need to go to the hospital? How was this knowledge—

Dr. David Heath: You have to do a lot of education, but also it's frankly trial—I wouldn't say trial and error, but people have to get to know the program and you develop what I call a brand image, because at first the ER physicians weren't too happy about sending patients, but now they just love us. But you have to sort of show them by experience and education, repeatedly.

M^{me} France Gélinas: Where would you say your clients come from right now? Are they mainly the ER physicians who refer or are they family physicians who refer, or where else?

Dr. David Heath: It's changed a lot. When we first opened, we actually couldn't get referrals in the hospital even though there was a desperate bed shortage. It's hard to believe. We got self-referrals, and from various people—teachers, home care nurses. Now they tell me—I haven't worked there for two years—it's mainly from the ER and from some family doctors.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much, Dr. Heath, for coming today.

DOWNTOWN GUELPH FASD SUPPORT GROUP

The Chair (Mr. Kevin Daniel Flynn): Our next presenters today are from the Downtown Guelph Fetal Alcohol Spectrum Disorders Support Group, Mary Cunningham and Shiona Watson.

Ms. Shiona Watson: Hi. Good afternoon, everyone. I'm Shiona. We're here today because we want to talk about the importance of including a large population of people with fetal alcohol spectrum disorders in this initiative and to tell you about why that's so important. I facilitate the caregiver support group in Guelph for those living with people with fetal alcohol spectrum disorder. I also do education and advocacy around this. I'm also the mother of a 14-year-old boy who has fetal alcohol syndrome and is profoundly deaf. We're people who live the experience of mental health issues in the community.

My husband and I adopted Mikey when he was 18 months old. We knew that he had fetal alcohol syndrome and we read all the books and we talked to people already living the experience. I always say that we kind of went into it with our eyes wide shut, because really, we knew nothing at all.

My son's birth mother, just to let you know how this played out, was abandoned by her own mother when she was three years old. She was physically and mentally abused by her father. She was left at the age of 12 to live with her next door neighbour, who sexually abused her. The social workers who worked with this lady were pretty certain that she also had fetal alcohol spectrum

disorder, according to her behaviour. There was no doubt that she loved her son, but she couldn't look after him. She had four other children before my son and she didn't have custody of any of them because of all the issues that she lived with. His birth father also—both of them were alcoholics, and he had other mental health issues too, including ADHD, and spends a lot of time at the Maplehurst corrections institute.

Ms. Mary Cunningham: I'm Mary Cunningham, and I'm a colleague of Shiona's from the downtown support group. I'm also a fetal alcohol spectrum disorder advocate and educator. I became this after we experienced FASD in our family. We adopted our second child when she was 13 weeks old and we knew absolutely nothing about FASD until she was 18. When she was 18, we discovered FASD for the first time and it was just like walking face first into that wall over there. It was stunning. It totally incapacitated us. We knew there was something terribly wrong, but we had no idea what it was. So after I more or less recovered from that, that's when I—I'm a retired teacher and I just kept on teaching. So I present in various provinces and was in the UK this spring doing this.

FASD has huge implications for the success of this Every Door is the Right Door initiative, because there are thousands and thousands of people with FASD in Ontario. It represents a reservoir of mental health issues because almost every single person with FASD will develop mental health issues. They are costing, on average, at least \$2 million each over their lifetime in extra social costs—you're basically hemorrhaging money here—and they're not getting the kind of treatment they need to keep them from developing addictions, to keep them from developing homelessness and so on and so forth.

Shiona and I are going to pass this back and forth to make it a little more interesting. Everything we're more or less saying is in the handout you have; all these children on the front have FASD. You also have a little book from the Public Health Agency of Canada, because we could spend all day talking about this and we'd only get started.

Shiona's going to lead off.

Ms. Shiona Watson: First of all, why is the recognition and understanding of fetal alcohol spectrum disorder so crucial to the mental health and addictions initiative? Fetal alcohol spectrum disorder is the most common birth defect in Canada, bar none. That's according to Health Canada. This is almost twice as many as have autistic spectrum disorder and between seven and eight times as many as those born with Down's syndrome.

Ms. Mary Cunningham: It affects at least 1% of all live births in Canada. That's what Health Canada's actually saying now. We know that's a very conservative estimate. At 1%, there are 130,000 Ontarians living with it, but in the field, it is suspected that it's probably 2% or 3%. So multiply 130,000 by two or three times \$2 million and you know why we have to do something about

this, plus the fact that it's really going to affect this initiative. If you understand it, it's going to work a lot better.

Ms. Shiona Watson: Although experts in the field currently say that there's roughly 1%, we do need an awful lot more research in the area, more studies and definitely more diagnosis. Trying to get a diagnosis in Ontario is extremely difficult and very frustrating for parents. There was a recent study, which has not yet been published, I believe, in Grey county, where they were isolating in utero alcohol exposure by—well, I'm going to say meconium, so they were guddling about in babies' diapers, basically. They reckoned that 4.17% of all the infants in their sample were alcohol-exposed. Now, this study only identified exposure after the 13th week of pregnancy. For all the women here, you know how long it takes before many of us know that we're pregnant, especially if we're young or we're not counting periods or we're on the pill or other birth controls that may not be effective at that time. So, many of the infants would be missed by this crucial time.

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FASD is usually misdiagnosed. Frequent misdiagnoses are ADHD and autism spectrum disorders. One clinical psychiatrist and FASD researcher from Northern Ireland, Dr. Kieran O'Malley, says, and I'm quoting him, "FASDs are the greatest clinical masqueraders, and their most common disguise is ADHD." That's from 2007.

Ms. Shiona Watson: So the same psychiatrist, Dr. O'Malley, says that FASD is often mistaken for ADHD because it looks like ADHD. However, the big problem with getting those two things mixed up is that the treatments would be very, very different. When we treat people with ADHD, we make an assumption that they can learn from consequences. This is something that is very difficult, if not impossible, for many people with FASD to do. This means that their mental health outcomes are very poor. It's very nice for families to think that their child only has ADHD, but the reality is that it's going to lead to very poor mental health outcomes.

Ms. Mary Cunningham: Noted FASD expert Dan Dubovsky, from the States, notes that often women who have mental health disorders—and we know that a lot of these are genetic, including depression and bipolar—drink to self-medicate and they become pregnant and they are still drinking in the pregnancy because it's self-medication. Consequently they are likely to have babies who have FASD and mental health disorders. It becomes a very vicious cycle.

Ms. Shiona Watson: Most people with FASD—that's between 90% and 95% of all of them—have no recognizable facial features or any other medical anomalies to let you see who they are. All they have are the dysfunctional behaviours, which we tend, as a society, to see as just bad people. FASD becomes an invisible disorder.

As Mary indicated, all the photographs on here, including that of my son, are of people living with FASD. Some of them have features and some of them do not.

Ms. Mary Cunningham: It also shows an awful lot of individuality. You can't go through a population and say,

"I know, I know, I know." There's a laundry list of symptoms. Consequently you can have very, very individual manifestations of it, but you almost always have dysfunctional behaviour.

Ms. Shiona Watson: Almost all adults with FASD, diagnosed or otherwise, will develop mental health problems, according to a study that Dr. Ann Streissguth, one of the leading researchers in FASD, did in 1996.

Ms. Mary Cunningham: These mental health problems tend to be very complex and frequently feature drug and alcohol addictions. In the field we have traditionally called both of these conditions secondary effects of FASD but now—I've been in this for about 10 years and now we're starting to see research showing that basically the mental health disorders are probably caused by the alcohol in utero. There's a lot more to go here. This is early times.

Ms. Shiona Watson: Dr. Kieran O'Malley again refers to this constellation of FASD, mental health disorders and addictions occurring together as "the triple threat of FASD." What he means is that a majority of people in this population, many of whom will be undiagnosed, are going to develop the mental health problems and addictions, and will be very difficult to treat.

Ms. Mary Cunningham: Common secondary effects with this are disrupted school experience; early dropout; sexually inappropriate behaviours; trouble with the law, often featuring recidivism; trouble staying in relationships; and trouble staying employed. You'll see these are our big, serious social problems. That's where the \$2 million is coming from.

That \$2 million, by the way, was a Dr. Sterling Clarren study and it didn't include legal costs for incarceration, so it's actually higher than that.

Ms. Shiona Watson: There's a very high rate of completed and attempted suicidal behaviour within this community. This appears to be related to an inability to cognitively understand the finality of completing suicide. It's also combined with the FASD impulsivity and high rates of self-injurious behaviour, which may unintentionally cross the line and result in accidental suicide.

Ms. Mary Cunningham: The secondary effects, as I just mentioned, are all recognizable as the biggest, most expensive and intractable social problems. Mental health is very often at the root of an awful lot of this. If we could understand how to intervene successfully in the life of a child who has FASD, we could prevent most of these.

Ms. Shiona Watson: And many of the adults with FASD have experienced physical, emotional and sexual abuse as children and may also suffer from post-traumatic stress disorders in addition to the FASD.

Ms. Mary Cunningham: Children in foster and residential care often have an FASD. One study in Ontario found that 31% had an FASD. One social worker from Alberta who often does work in Ontario estimates 80%. One young woman in care went through approximately 75 placements before her FASD was recognized. She is

now in a much more supportive environment, but consider the mental health ramifications of that.

Ms. Shiona Watson: Co-occurring mental health diagnoses are common with FASD. Dr. Kathryn Page from California calls this an “alphabet soup of diagnoses”. She lists the following as common diagnoses given in addition to or in place of FASD: There is ADD or ADHD, various forms of depression, reactive attachment disorders, conduct disorder, borderline personality disorder, obsessive compulsive disorder and oppositional defiant disorder.

Ms. Mary Cunningham: Some of the above are real, co-occurring disorders and some we consider misdiagnoses. Dr. Page theorizes that as a person, usually the caregiver, goes from clinician to clinician basically saying, “You’ve got to do something about this child. Give me something because their behaviour is really difficult to deal with,” that’s where we accumulate this huge list, this alphabet soup.

Ms. Shiona Watson: Many people with FASD would qualify for what’s called a dual diagnosis if in fact they actually had a correct FASD diagnosis. The National Coalition on Dual Diagnosis in Canada notes, “Those with dual diagnoses”—that is, developmental disorders and mental illness—“are often denied services because they are too complicated to treat.”

Ms. Mary Cunningham: As Shiona mentioned previously, getting a diagnosis of FASD is very, very difficult. It’s very difficult in Ontario. It’s very difficult across Canada. It’s a complicated diagnosis. It needs a multi-disciplinary team of medical and psycho-social professionals.

Ms. Shiona Watson: The research shows that children with FASD who are diagnosed prior to the age of six—there we go. We were just telling you how difficult it is for anybody to get a diagnosis and now we’re saying that we need them to have a diagnosis before they get to age six. Then, if they do not have that diagnosis and they are not supported, they tend to develop many, if not all, of the secondary effects of FASD. This seems to be related to the fact that these children received services that supported their needs much earlier, that is, if they were diagnosed before age six.

Ms. Mary Cunningham: Changing the topic slightly here, what you have to understand is that all people who have FASD have permanent brain damage and it usually affects the following areas, any one or all of them: cognition and effective decision-making, adaptation—that’s probably the most complicated effect—attention, reasoning, memory and language development. The language development is odd in that people with FASD are often extremely good talkers. They’re able to talk the bark off trees basically, but receptively, they’re not getting the message. We have teachers who say to us, “Listen to them. How can anything be possibly be wrong with them? Listen to them talking.” But it’s not getting it.

Ms. Shiona Watson: The majority of people with FASD show only dysfunctional behaviours in the five areas noted above and they receive no support or

understanding that it’s permanent brain damage caused by alcohol, that that’s what’s causing their behaviour. There’s a tendency in society to believe that behaviour is something that we always have control over, but for people with brain damage, that simply is not true. They look instead as non-compliant, uncooperative, resistant, manipulative and unmotivated.

Ms. Mary Cunningham: As I said, most people with FASD can talk the talk brilliantly, sound like they know what they’re talking about, but because of the brain damage, receptively, if you ask questions, they’re not going to understand what they said. This gets them in trouble all the time. They sound a lot more functional than they actually are.

Ms. Shiona Watson: Another huge issue with this population is that mostly the IQs are above 70, which is the cut-off for many, many services that they could have been eligible for. So although these people have an IQ above 70, they often are not very good at being able to make any kind of use of that. Ninety-one per cent of children with ARND—that’s alcohol-related neuro-developmental disorder; essentially, that’s FASD without any identifiable features—have IQs of between 70 and 130. Without these services, obviously these children, and later when they become adults, are at greater risk of depression and other mental health issues and addictions because their self-esteem and confidence in their own abilities are so low.

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Ms. Mary Cunningham: Most people with FASD would like to be able to behave properly and fit in. That’s probably their greatest wish: “I just want to fit in.” It is not that they won’t do something; they can’t. They simply can’t do it. Changing this paradigm is one of the critical things we have to do, to understand that they can’t do it, it’s not won’t, and that comes from Diane Malbin, who is an acknowledged expert in this area.

Ms. Shiona Watson: When the brain damage of FASD is not recognized or understood, the standard psychiatric and psychosocial attempts to support a person with it tend to fail miserably. For example, behaviour modification is really useless with this population. Reward systems, relying on learning theory and learning from one’s mistakes: These are all cognitive activities that require good use of the frontal lobes, which is something that people with the brain damage of FASD cannot do.

Ms. Mary Cunningham: Psychiatrists and other mental health care professionals generally do not understand our people, and these apparently non-compliant behaviours of people with FASD tend to get them fired from treatment. They are told to come back when they can comply. Well, they can’t comply, so they’re out of that treatment program and looking for another treatment program. But—

The Chair (Mr. Kevin Daniel Flynn): I’m going to have to jump in there, Mary. We’re a little bit over time, but we do have your last page and we do have all the recommendations you make from 29 to 34. So if you could just maybe summarize really quickly.

Ms. Shiona Watson: We were actually going to finish there, so that's very clever of you.

The Chair (Mr. Kevin Daniel Flynn): Okay, perfect.

Ms. Mary Cunningham: We were just going to say that we've presented all these negative stereotypes—well, they're not stereotypes; these are all researched. But I have never, ever yet met a person with FASD, and I've met hundreds of them, who did not have an aptitude or a really strong case. So if we could get to supporting that and providing support for the brain damage, then we would be able to do something positive here.

Ms. Shiona Watson: And if we could get everyone in the government to understand what FASD is, that would be a huge start.

The Chair (Mr. Kevin Daniel Flynn): Well, I think you just got eight or nine of them here, so it's a start.

Ms. Shiona Watson: Thank you very much for listening.

The Chair (Mr. Kevin Daniel Flynn): Actually, if you could explain maybe one thing for the whole committee. You talked about a link between FASD and autism. Were you saying that FASD causes autism, or you're saying that FASD is—

Ms. Mary Cunningham: It's mistaken for.

The Chair (Mr. Kevin Daniel Flynn): So we could be treating kids for autism who actually have FASD?

Ms. Mary Cunningham: We can tell you for sure you are.

Ms. Shiona Watson: Lots of them. Because they can get services if they're diagnosed with autism, but not for FASD.

Ms. Mary Cunningham: And frequently, autism is a more socially acceptable disorder to have.

The Chair (Mr. Kevin Daniel Flynn): Yes, we were talking about that before. Thank you very much for coming today. It was good to see you both.

Ms. Mary Cunningham: Thank you for having us.

KEVIN TREGUNNO

The Chair (Mr. Kevin Daniel Flynn): Thank you. Okay, after Mary and Shiona, our next speaker is Kevin Tregunno. Kevin?

Make yourself at home. We've still got some clean glasses if you need some water. Everybody gets 15 minutes, Kevin, so you can use that time any way you like.

Mr. Kevin Tregunno: I've actually prepared a short speech and left lots of room for questions.

The Chair (Mr. Kevin Daniel Flynn): Perfect. Well, I'll let you just handle your own time, then.

Mr. Kevin Tregunno: Okay. I'll begin now.

At the age of 17, I remember reading about schizophrenia in a psychology textbook. It seemed like the absolute worst kind of illness you could get, in my mind. I made the connection due to my own stigma that these were the people who you only ever saw in mental hospitals and didn't see in public. To me, it was the pinnacle of insanity. It seemed so far removed from anything that

could happen to me that it occurred to me at the time that this could never happen to me.

Boy, was I wrong. At the age of 19, I would learn what it meant to be a person with the label of schizophrenia and a recipient of psychiatric services.

I would also learn that this very thing, though bitter, would transform my life into something tremendously meaningful: a life with purpose and promise. Though it took me years to accept this illness due to stigma, internal and external, I eventually found hidden strengths and determination which have, in ways, carved my character and life into this outstanding person who stands before you. I've risen up in the face of poverty, homelessness and despair. I have bounced back from the deep chasms of psychosis, from delusional to inspirational, from thought disorder to enlightened, from isolated to engaged and engaging.

My story, though unique, is testament to other unsung heroes alike who have faced tremendous obstacles and barriers, adversity and strife, yet still have risen up to recreate and recover. My story isn't so much important as is the underlying meaning: that we do recover, and we have a lot more to offer than what was previously imagined.

Right now I work as a peer support worker at the Halton safe beds program. I see the tremendous qualities in my fellow consumers who are not only struggling to discover what life is about; they're discovering what it means to live with a serious mental illness in all its various manifestations. It's not a welcoming feeling.

I believe we need to do more to combat stigma. Part of that could be reaching people in their school years, as early as elementary school. Early intervention is key. There needs to be early detection and intervention in all realms of mental health, not just psychosis but depression, anxiety and addiction. Early detection should start in the schools.

More needs to be done for the youth at risk in these areas: homelessness, addictions and mental illness.

I look forward to the day when the young child who is at risk is supported throughout so that he or she never has to live through what I've been through. No one should slip through the cracks, not in a day like today. There needs to be more support and education for and about mental illness at a younger age so that we grow up knowing at a younger age more about the realities of mental health and addiction.

Combating stigma should be part of early intervention for addiction and mental illness. It involves all of us. I've lived as a person with schizophrenia for 10 years. I've worked in mental health for close to five years as a peer with an education and a purpose. It took me many hardships to get here, and I stand before you now as a witness and a survivor.

I want it to be easier for people just like me who might be overwhelmed with school due to symptoms of their illness. There needs to be more done to help people with serious mental illness meet their goals and dreams, whether that be school or work. Whatever it is, if we're

going to attempt to live on disability and have the incentive of part-time work, then we need better options. We need better opportunities for us to go to school and meet our goals.

I've also worked as a recovery support worker for the early intervention program in Hamilton. I see many people dealing with psychosis who have big dreams but are stuck in some ways with what's offered to help, and it's not good enough. I propose we offer more opportunities for people to work through funding programs that offer a more extensive plan than what employment supports offer, a program with more avenues and more financial support.

I also propose that peer support be made mandatory for every mental health program in the system, from clinical outpatient care down the line to early intervention, from hospital settings to community programs. The help of our peers can mean more than any mental health worker.

Being on disability doesn't offer much promise of an education. It offers just barely enough to get by, and in many cases not enough. Right now, I'm working at CMHA Halton safe beds. I see the people on ODSP, and a lot of them have slim options.

I believe we, as consumer-survivors and those of us witness to this, have so much potential and so much promise despite our illness and the obstacles we face. We have so much to offer, so much to give. We need to be able to have the chance to give and have the help we deserve to get there. I believe that we as people with serious mental illness can do anything we aspire to with the right help and supports.

Being diagnosed with a serious mental illness can act like a wall between you and others in society. We need to break down those walls and build a community where we are respected and appreciated. In my early years, I felt the weight of those walls and it took me years to feel empowered.

My experience as a recipient of mental health services does not end as a consumer and a peer support worker; it's also as a family member. My mother worked as a psychiatric nurse for 30 years. At the age of 57, in March 2009—this year—she lost her job, she lost her house, she lost her car, and she became homeless. She was suddenly a consumer of mental health services—not just any, but the one I work at. As a son with schizophrenia, I reached out to places and I told my story. How did this happen to my mom? Why wasn't she connected with services earlier? It's complicated, I'm sure, but these are the questions we need to look at.

You can bet stigma played a role in preventing my mom from seeking help. She was supposed to be the helper, not the one who needed help. She often talked about never wanting to go to the hospital for this reason. How can homelessness be the deciding factor in whether or not a person gets the help they need? How did her alcoholism and mental health issues and isolation go on for so long? Why aren't services reaching out to people more? Early intervention and detection are key to this,

along with combating stigma and offering more opportunities for consumers to reach their potential.

I believe we live in a society where people with mental illness should not only be understood and accepted in society, but should be appreciated, not just within the segmented mental health system but in all of Canada.

I'll now answer any questions anybody has.

The Chair (Mr. Kevin Daniel Flynn): Thank you. You've left about three minutes for each party. I'm not sure who's first. Is it you, France?

M^{me} France Gélinas: Sure. I'm not keeping track, but I'm happy to go first.

The Chair (Mr. Kevin Daniel Flynn): You're all getting three minutes anyway.

M^{me} France Gélinas: All right.

You mentioned a number of times about how early intervention certainly would have changed the atrocity that your mother went through, and you talked about it for yourself also. Where do you see this happening? Who should be the people doing the early intervention? How should it be rolled out?

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Mr. Kevin Tregunno: I think it needs to happen as early as school years, like elementary school. If, by some kind of campaign, through advertising, reaching kids at a younger age through some kind of activity that the elementary school students could do to learn about people with mental illness, to learn about the realities of mental illness, the statistics about how many are likely to have it and everything—they could make it something fun and entertaining but still learning about it, and then, from there, continue to get educated about it as they grow up. But it needs to become a reality for people, because people are becoming so struck by it that they don't see it coming and they don't expect it and they're not prepared. If we can intervene at an early age, you can ensure that people will have a better outcome.

M^{me} France Gélinas: You certainly speak very positively about peer support. You're not the only one. A lot of people have come forward. Do you have ideas as to how it should be rolled out province-wide, how it should or should not be structured and organized?

Mr. Kevin Tregunno: I don't really have too many ideas around that. I think there should be more opportunities for full-time work, because a lot of the opportunities are part-time or casual. But I think there needs to be more opportunities for full-time. In some ways, I think it might be better if it's standardized and there's training that's standardized throughout the province. I haven't really put all that much thought into it, but yes, I think—

M^{me} France Gélinas: The peer support that you're offering: It's part of your job, or do you do this—

Mr. Kevin Tregunno: Yes, it's part of my job.

M^{me} France Gélinas: It's part of your job. It's not volunteer work.

Mr. Kevin Tregunno: No.

The Chair (Mr. Kevin Daniel Flynn): Okay, thank you, France. Let's go on. Who's speaking? Helena?

Ms. Helena Jaczek: I wanted to pick up on the peer support issue as well. We've certainly heard a lot about it. Could you just describe, even for us, how you were trained to be a peer support worker? Obviously, you've got your personal experience, but what sort of training did you go through?

Mr. Kevin Tregunno: I started off with a diploma in recreation and leisure services at Mohawk College, and through that, I volunteered at the disability office at Mohawk College. I was a peer mentor for students with learning disabilities. From there, I volunteered quite a bit. I received training from the Ontario Peer Development Initiative around peer support in Burlington. From there, I volunteered and I got an initial job working at the Cleghorn program in Hamilton, an early intervention program. From there, we worked to develop the role. That's where I really got my know-how and everything to do peer support.

Ms. Helena Jaczek: We heard this morning from the Gorski Centre for Applied Sciences. Are you aware of that particular program?

Mr. Kevin Tregunno: No, I'm not. I'm not sure. Is that in Toronto?

Ms. Helena Jaczek: It's web-based.

Mr. Kevin Tregunno: No. I've heard of it, but I'm not very familiar with it.

Ms. Helena Jaczek: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you. Anybody else from that side? We've probably got about a minute left. No? Okay. Christine?

Mrs. Christine Elliott: Just one question: I'm interested in some of the issues concerning the barriers to employment, and I think it's probably fair to say that there's a lot of employer education that needs to happen, but also with the way—we've heard from other people that it's the way that the ODSP payments are set up. Do you have comments that you'd like to make on that?

Mr. Kevin Tregunno: Yes, actually, the one thing that bothers me the most is that if I make over a certain amount of money, I won't get benefits. For instance, if I get a job—when I was working at the Cleghorn, I was part-time, but I was above the limit for ODSP, so that meant I had to pay for my medication, which is a huge barrier because it's not easy. Even with Trillium, it's not easy to pay for your medication. To not have the support of that drug card means that my health is compromised and I can't do my job as well. You know, I ended up leaving for that reason, partly. I mean, that's a major issue, too.

Mrs. Christine Elliott: You'd recommend that's something we should take a look at, then, in terms of the system itself.

Mr. Kevin Tregunno: Yes, for sure.

Mrs. Christine Elliott: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming out today.

Mr. Kevin Tregunno: No problem.

MARGARET FRAZER HOUSE

The Chair (Mr. Kevin Daniel Flynn): Our next two speakers today are from Margaret Frazer House: Diane Walter and Elaine Flis, if you'd come forward. Those mics move pretty easily, I think, if you need to pull it closer.

Interjection.

The Chair (Mr. Kevin Daniel Flynn): Okay, thank you very much. If you'd introduce yourselves, because obviously there's more than two of you. You've got 15 minutes, like everybody else. Use that any way you see fit. If you can leave some time at the end for questions, that would be great.

Ms. Elaine Flis: Great. Thank you very much. We do have one more person with us today. I hope that it's not too much of an inconvenience, but we did want to bring someone with lived experience with us to share her story.

My name is Elaine Flis and I'm the volunteer chair of the board for the Margaret Frazer House. I'd like to begin by thanking the committee for providing us with the opportunity to make our presentation today. With me is Diane Walter, our executive director, who's to my far right, and Tina Swift, who has lived at Margaret Frazer House and now lives independently.

Margaret Frazer House is a transitional shelter for women with severe mental illness, and we provide a continuum of care for our residents. Diane will speak more specifically about Margaret's itself.

We are putting forward three recommendations to the committee today. Firstly, we recommend that the Margaret Frazer House model be rolled out across the province. As you will hear, our model is unique and successful in helping women with mental illness. Secondly, we recommend that psychotherapy be covered under the Ontario health insurance plan, since we know this is crucial to one's health care and leads to success when used in combination with other medical and pharmaceutical supports. Thirdly, we would like to see mental health parity in Ontario with the United States with respect to insurance companies, so that no one person with mental illness is rejected and goes without. Many therapies can be expensive and out of reach for individuals who cannot afford their prescription medication.

At this time, I'd like to turn it over to Diane to speak specifically about Margaret's and our unique model, which offers women with mental illness a continuum of services. Diane?

Ms. Diane Walter: Hi. Good afternoon, everyone. My name is Diane Walter, and I'm the executive director of Margaret Frazer House, a mental health agency which provides a continuum of housing and supports to women who are living with mental illness and addiction to a lesser degree.

I'd like to give a brief history of the agency. It was started by a group of women which included the late Margaret Frazer and the late, renowned journalist June Callwood. The agency will celebrate its 25th year in

operation. It came out of the shelter—they created a shelter called Nellie's and they observed that a subgroup of women had presented with different issues than women who were fleeing abusive relationships. The staff and Margaret and June sort of lobbied the then-Conservative government. The then-minister was Larry Grossman. They lobbied really aggressively for funding for an agency. Larry Grossman, in his wisdom, funded 10 transitional beds for women with serious and persistent mental illness. We have grown since then.

We advocate for safe, affordable housing for women that is women-centred and which operates from a culturally sensitive place. This is not only ideal for some, but is recommended for a group of women who are living with mental illness and addiction. We understand that women's housing needs are distinct from those of men and are embedded within the context of poverty, social, racial and gender inequalities and violence against women.

I'd like to talk about our services. Our model of service is based on a woman-centred care and recovery model. It is an approach to housing and support that emphasizes a client's potential for recovery. Recovery is seen as an individual journey, a personal journey, requiring hope, a safe and secure base, supportive relationships, empowerment, social inclusion, coping skills and finding meaning. Client-centred refers to a joint participation of the client and the service provider. It requires consumer participation at many levels with a professional and supportive organizational structure and a clear understanding of the population we serve.

We currently have 14 transitional beds, two crisis beds, 20 aging-at-home units in the community and 18 scattered units in the community. All of the above housing and supports are staffed 24 hours to support as needed. Our staff are culturally sensitive. We have a psychiatrist and we work in collaboration with community agencies and the hospitals.

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Our governance model is one that meets the criteria for best practice, but additionally, our board of directors must have at least two consumer-survivors on the board, thus keeping the service accountable and, at minimum, some degree of authenticity in its programming. Our programming includes social recreation, art therapy, a peer support program, French classes that are taught by consumers and a community dining program. Management of the housing and its program is done in a collaborative fashion. Consumer and client voices are heard and integrated into service delivery.

How do we measure success? Well, I suppose, just in tangible ways: cost-benefit analysis. We do exit interviews and the women tell us that we are doing a great job. And we have a waiting list that we—as a matter of fact, we just dissuade waiting lists because we can never meet that demand.

There's still a dire need for housing and supports for women with mental illness provided like what Margaret's provides, yet there isn't enough. I also think women's

housing was not recognized by the commission and I think that can only be an oversight.

I thank you for listening to me this afternoon. This is one of the forums that will give us an opportunity to talk about the issues of mental illness and addiction in Ontario. I urge us to continue to listen and learn, and then act. Thank you.

Ms. Tina Swift: I guess that leaves me. Hi, my name is Tina Swift and yes, I'm a consumer-survivor at Margaret's. I'll give you a little bit of my history and what led me into Margaret's. I have really severe mental illness and at times have been unable to work. Um, there was one job that I had to leave and I didn't have any benefits, so here I was living on CPP money—that was \$721; rent was \$500—and I couldn't afford my drugs. Yes, that was a bit too much. So I ended up in a shelter, and I was so, so ashamed.

As you see, I have a really good education. I've had great jobs. Um, to have, first of all, a mental illness take me where it's taken me and to be in this group that I was in at the shelter was terrifying—it was terrifying. I was introduced to Margaret Frazer House then and I kept on refusing because they, um—I'm sorry there are so many "ums"; I'm nervous.

The Chair (Mr. Kevin Daniel Flynn): We're all nervous. You should see the job we have.

Laughter.

The Chair (Mr. Kevin Daniel Flynn): You're doing a great job.

Ms. Tina Swift: Thank you.

I kept on refusing Margaret's, hoping that I could save up the money again for first and last and be independent again. It never worked. The finances were just the same. So I went to Margaret's and I literally kissed the floor of the bedroom that I got, because I had a bedroom, I had safety. I got addicted to painkillers a long time ago and I was in recovery in the shelter. It was hard—I had five years, then—and here was a safe place. I didn't have to keep all my guards up and it was a lifesaver.

Being there was interesting. It challenged all of my preconceptions of mental illness, it challenged me to change my patience level, but it also did give me two lifelong friends and it's given me a home. I can't be around my family, so Margaret's is my family. There's always somebody there for me. I've been away from Margaret's for a lot of years now and I'm living in one of their independent units with the aging-at-home project.

Margaret's put a registered nurse back into society and employment. Without Margaret's, I would have just kept on stumbling along and my good skills would have been lost.

I'm thriving. I know I have the support. I really believe that there have to be more Margaret's, because there are a lot of women out there who are falling through the system who are professionals, who are mothers, who are just a full range.

Without Margaret's service, I'd be totally lost. So, yes, it's a really necessary thing and, hopefully, I've made a bit of a difference. Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you.

Ms. Elaine Flis: Just in closing, very briefly, if I may?

The Chair (Mr. Kevin Daniel Flynn): Yes.

Ms. Elaine Flis: In closing, I'd like to briefly share my experience with Ontario's health care and insurance systems.

Last September, I was diagnosed with bipolar disorder, after years of misdiagnosis. I'm fortunate to have an excellent health care team that supports me, although there are many gaps in our system. Specifically, I'm a sole proprietor, and as such, I'm denied medical insurance by all companies I approach.

My pharmaceutical bill is approximately \$600 per month out of pocket. My weekly psychotherapy treatment costs \$85. My group therapy is approximately \$200 per month. My total health care bill, in a society that claims to have universal health care, is approximately \$1,200 per month. This is out of reach for most people and why we make the recommendations we do, stated at the beginning of our presentation. If it weren't for family and friends and their support, I would be homeless or worse.

Thank you again for the opportunity, and if time does permit, we'd love to take some questions.

The Chair (Mr. Kevin Daniel Flynn): Well, time does permit.

Ms. Elaine Flis: Perfect.

The Chair (Mr. Kevin Daniel Flynn): It doesn't permit a lot, but it permits some. Why don't we start on this side? Anybody? Liz.

Mrs. Liz Sandals: What you're describing is supportive housing plus treatment. Is there a treatment component at Margaret Frazer House?

Ms. Diane Walter: We have a visiting psychiatrist who comes to the house twice monthly.

Mrs. Liz Sandals: Okay. So in terms of putting together that model, then, which seems to be really successful, of supportive housing and a psychiatrist who's available, where do the pieces of funding come from, what is fundraising and how do you pull this very successful model together?

Ms. Diane Walter: It's a very interesting dance. We're funded by the Ministry of Health. Now the Toronto Central LHIN manages that funding.

The psychiatrist is actually done through a partnership with St. Mike's, through the inner city medical team. The Ministry of Health pays them directly. That came out of sort of a—

Mrs. Liz Sandals: It's a community treatment bucket of some sort and you're on the visitation route?

Ms. Diane Walter: Yes. It was a creative way of having a psychiatrist visit, because we have women who absolutely flatly refuse to go to a psychiatrist or to see any doctors at all. We have a brilliant psychiatrist. She's just wonderful for the job. She comes in and she sees them, and she'll see them anywhere. She actually goes out into the community and sees women in our satellite housing as well.

The Chair (Mr. Kevin Daniel Flynn): Thank you. We'll go on to Sylvia.

Ms. Sylvia Jones: Thank you for coming. I'm not from Toronto so I'm going to ask some questions because I'm not familiar with Margaret Frazer House. You mentioned that there is a waiting list but you didn't really explain that.

Ms. Diane Walter: Well, I guess, why get someone's hope up? In the transitional program, you can stay for two years. The permanent housing, obviously—

Ms. Sylvia Jones: Okay, so your average stay is two years?

Ms. Diane Walter: It's two years, but the reality is, some people do stay longer because you discharge someone and they're going to end up in hospital. You've got to wait until folks are really stabilized before you discharge.

Ms. Sylvia Jones: So you would be encouraging people to look elsewhere for other programs while that list is happening.

Ms. Diane Walter: Absolutely, yes.

Ms. Sylvia Jones: A last, really quick question: Where are your referrals coming from at this point?

Ms. Diane Walter: Primarily, 80% come from hospitals. Some come from shelters and family members, but I would say that between 80% and 85% come from hospitals.

Ms. Sylvia Jones: Thank you.

The Chair (Mr. Kevin Daniel Flynn): France, you've got about a minute.

M^{me} France Gélinas: Continuing on what Sylvia was talking about, the average length of stay is two years?

Ms. Diane Walter: For the transitional housing.

M^{me} France Gélinas: For the transitional housing, it's two years. Do most of the tenants in your other housing complex come from the transitional housing?

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Ms. Diane Walter: Most of them do. As a matter of fact, that model is really quite lovely because there's a fluidity. If a woman is not doing well in the permanent housing, she can come back to the crisis bed and avoid a hospital stay. I can tell you, hospitals are not fun places to be. So they can come to the crisis bed and stabilize and when they get better, they go back, and there will be staff to visit them in the community.

M^{me} France Gélinas: So how many different levels of support do you offer? I take it that in your transitional stage, it's 24/7?

Ms. Diane Walter: It's 24/7.

M^{me} France Gélinas: And then it goes to nothing at all?

Ms. Diane Walter: And then as needed. With the aging-at-home, that's a very different project. That just started a year ago. It's as needed.

M^{me} France Gélinas: As needed, and the money to pay for the staff comes from the Ministry of Health?

Ms. Diane Walter: That's correct.

M^{me} France Gélinas: Okay, all of it either through the aging-at-home strategy or through the transitional beds?

Ms. Diane Walter: Yes.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for presenting today. You didn't look nervous at all, Tina.

Ms. Tina Swift: I wing it good.

The Chair (Mr. Kevin Daniel Flynn): You did a good job. Thank you for coming.

MARVIN ROSS

The Chair (Mr. Kevin Daniel Flynn): Our next speaker this afternoon is Marvin Ross. Is Marvin here?

Mr. Marvin Ross: Yes, I am.

The Chair (Mr. Kevin Daniel Flynn): Please come forward, pick a comfortable seat and make yourself at home.

Mr. Marvin Ross: My first task is to pull the chair out.

The Chair (Mr. Kevin Daniel Flynn): Like everybody else, you get 15 minutes. You can use that any way you see fit. If there's any time at the end, we'll split that among the parties.

Mr. Marvin Ross: Okay.

The Chair (Mr. Kevin Daniel Flynn): The floor is all yours.

Mr. Marvin Ross: Thank you for the opportunity to present to you today. I'm going to focus on schizophrenia, a topic that I am far too familiar with as a parent. In addition, as a medical writer, I have used my expertise to research the disease and I wrote the book *Schizophrenia: Medicine's Mystery—Society's Shame*. The book has received excellent reviews and I will leave you a copy at the end of my presentation.

The subtitle of my book says "Society's Shame" and it is when we look at some facts about our treatment of the victims of this disease. The World Health Organization states that 44% to 70% of people with schizophrenia receive no care at all.

Dr. David Dawson, a former professor of psychiatry at McMaster and chief psychiatrist at what was the Hamilton Psychiatric Hospital, stated in the preface to my book that "the mentally ill of many western countries are not faring as well as they might have in 1960 or 1970 despite our advances in knowledge, treatment, and our nations' wealth." Michael Wilson stated that only about 25% of those who need treatment actually get proper treatment. There would be a public outrage if these same statistics applied to those with heart disease or cancer.

Wilson also stated that the system in Ontario is based on 30 years of neglect that had led to staff shortages and little evidence-based treatment. And by the way, Wilson co-chaired a series of 11 reports on mental health in this province commissioned by the former Conservative government that was presented just before the McGuinty government took office. I would suggest that you take a look at them, if you haven't already, as part of your deliberations.

A 2005 report by Canada's correctional investigator found that between 1998 and 2004, the number of prisoners with psychiatric illnesses doubled. It went up

50% while the total number of prisoners declined by 12%. This does not mean the criminals are developing mental illnesses; it means the mentally ill are being criminalized. Instead of spending weeks and sometimes months in an underfunded, neglected but otherwise humane treatment facility—a mental hospital—they are being cycled through the courts to jails, hostels and street corners, and back through the courts at far greater expense than good treatment facilities would cost. A Canadian Mental Health Association official, Penny Marrett, said, "Our prisons have become warehouses for the mentally ill due to funding cuts and closures...."

A 2005-06 report by the Canadian Institute for Health Information found that there are significant numbers of homeless people with psychiatric disorders. Many of the people who you see sleeping on sidewalk grates and begging for change not far from this Legislature have untreated psychiatric disorders. They deserve to be treated. Some estimates go as high as 70% of long-term homelessness is caused by mental illness.

A study reported in the Archives of General Psychiatry in 2007 that combined data from 37 other studies in numerous countries found that people with schizophrenia have a death rate two and a half times that of the general population. Another study, in the Journal of the American Medical Association, found that people with serious mental illness lose 25 years of life expectancy compared to the general population. The conclusion from these studies by one of the authors is that this is a "tragic reflection on how sub-optimal our current treatments are."

But none of this has to be. These problems do not exist in the Netherlands or Norway. Yale psychiatry professor Thomas McGlashan said of Norway that any mentally ill person found on the streets would be connected with an outpatient clinic and provided with a doctor and a nurse to ensure his or her well-being. I would strongly suggest that this committee look at what is being done in those two countries.

My friend Ian Chovil, who I have written about, is an interesting case: He spent over 10 years living on the streets with undiagnosed schizophrenia, addicted to drugs and alcohol. In 1985 he was living in his car in Toronto when he was arrested. The court sentenced him to three years' probation and required him to see a psychiatrist. This he did in Guelph. He improved sufficiently that he was able to eventually get a job at the Homewood, a world-famous psychiatric facility in Guelph, and set up and maintain a very good, informative website on schizophrenia. He is now retired, but his website is still on the Internet, and that is chovil.com.

He once commented to me, "It is only too self-evident to me that I have permanent damage that I must live with because I was not treated in the first six months. It is something that I think about every day, something that I have to re-accept every morning."

The longer that schizophrenia goes untreated, the more brain damage there is. The more frequently one has severe relapses, the longer it takes to recover, and that

recovery is not back to the same state the person was in before the relapse.

One of the reasons for this state of affairs is that many in society still do not recognize psychiatric illnesses as real diseases. Look at the recent report called *Every Door is the Right Door*: a commendable attempt to improve conditions, but they talk about prevention. If they truly recognized psychiatric illnesses as diseases, they would not talk about prevention. After all, how can you prevent something when you don't know what causes it? We can prevent a lot of heart disease, skin cancer and type 2 diabetes through lifestyle changes because research has uncovered some of the factors causing those diseases.

Medicine cannot prevent diseases like Alzheimer's, MS or ALS because it does not know the cause. Similarly, medicine cannot prevent schizophrenia, bipolar or depression because no one knows what causes them. We have theories and ideas, but as of now we do not have any understanding that could lead to primary prevention, and secondary prevention is just what I talked about a few moments ago: early diagnosis, early and adequate treatment, rehabilitation and health maintenance.

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Schizophrenia is a disease of the brain that just happens. It is not a "mental health issue," a term that is often used. We don't talk about people with insulin-dependent diabetes as people with pancreas issues. They have a disease. Schizophrenia is a disease that causes, or is caused by, significant changes in the brain. There are well-documented structural abnormalities, neurological abnormalities, neuropsychological abnormalities, electrophysiological abnormalities and cerebral metabolic abnormalities. These changes have been documented in people who have never been treated, although the opponents of drug treatment would argue that the changes are the result of prescribed medicines and nothing else.

Imaging studies of the brains of untreated people with schizophrenia have shown that there are significant differences when compared to the brains of matched healthy people. The effect of antipsychotic drug treatment on these sick patients results in their brains gradually starting to resemble the brains of the normal healthy controls.

The people you see pushing a shopping cart with all their worldly possessions in it while mumbling incoherently to themselves or shouting rhetoric on the street corner, or living in a cardboard carton, are sick. They deserve humane care, humane consideration and treatment, so why aren't we giving them treatment?

A large part of the reason is that we allow them to make their own treatment decisions, something they do not have the capacity to do. Part of their illness is their inability to understand. This is a condition called anosognosia. They are so sick and delusional that they do not know they are sick and refuse treatment, and our society thinks that this is okay.

Most opponents of compulsory treatment cite John Stuart Mill's *On Liberty*. Mill said, "That the only purpose for which power can be rightfully exercised over

any member of a civilized community, against his will, is to prevent harm to others." When Mill wrote that, there were very few medical treatments for anything, let alone psychiatric disorders.

But Dr. Richard O'Reilly, a psychiatrist in London, Ontario, and the former president of the Ontario Psychiatric Association, points out that Mill also said in the very next paragraph: "Those who are still in a state to require being taken care of by others, must be protected against their own actions as well as against" personal "injury."

We do that for the elderly with severe dementia and Alzheimer's. We do not allow granny to refuse treatment for her dementia and to live in a refrigerator box outside, so why do we do that for young people with schizophrenia? It is cruel and inhumane for any caring society such as ours to allow people who are sick to remain sick.

In fact, the most effective anti-stigma strategy is not to try to educate the public, but to provide treatment for those who need it. Tragedies like the Virginia Tech shooting or the Greyhound bus beheading only fuel negative views about mental illness. Preventing these events by providing treatment for those who commit them, or who are likely to commit them, does much better.

Psychiatrist Dr. Sally Satel said in the *New York Times* recently, "No matter how sympathetic the public may be, attitudes about people with mental illness will inevitably rest upon how much or how little their symptoms set them apart."

In the western world, with growing affluence and increasing attention to civil liberties, in the 1970s mental health laws changed. They were rewritten to protect individual rights. I am told that the authors of Ontario's Mental Health Act did not expect the results that have become so obvious over the past twenty years. They thought the mentally ill would still get good treatment, but that within that right to receive treatment their other rights would be protected. At the time, cynical psychiatrists often joked about the mentally ill now being allowed to die in back alleys with their rights intact. The laws created due process and caused a careful examination of forced treatment, but were ultimately based on a fantasy that those without insight into their illness could make sound treatment decisions. The result has been that many seriously mentally ill have lost their right to treatment.

In several European countries, the same countries that have excellent social welfare systems, excellent systems for the care of the mentally handicapped, and countries that are renowned for their approach to civil liberties, it has been recognized that we threw away the right to treatment when our laws overemphasized the civil rights of the mentally ill. It is the attitudes, resources, rules, practices and laws of these countries that we should study and emulate.

In conclusion, I would like to pass on some comments from my family.

My wife would like me to tell you that if our health system cannot do a better job of providing treatment for

people with schizophrenia, then we, the families of those individuals, should all be given free antidepressants.

My son works for a psychiatric rehabilitation program in Hamilton as a peer counsellor. A previous speaker talked about peer counselling. The LHIN that is responsible for that program has just cut off their funding. As a result, the clients—and, since you're writing, I'll mention that it's the Wellington Psychiatric Outreach Program—some of them, will lose their support. And the peer support workers, for whom this job helps with their self-esteem and feelings of self-worth, will be unemployed.

As I promised, I will leave you a copy of my book. There is no test, so don't worry when you read it. I'm also going to give you a DVD of a feature film on developing schizophrenia that's going into release in the US in October. It was written and directed by a psychiatrist. It was shot in Hamilton, and it is probably the most accurate depiction of what it's like to develop schizophrenia that I've ever seen. In addition to the 90-minute feature film, there are also three extra scenes that were added to the DVD as little extras that are very, very informative, in my humble opinion.

Thank you for your time. I'd be happy to answer any questions.

The Chair (Mr. Kevin Daniel Flynn): We'd be happy to hear your answers, but we have no time. That was a wonderful presentation, though. I thought it was very thorough. Thank you very much for coming here today. If we can get those books and DVDs from you.

Mr. Marvin Ross: I will leave a copy of the book and the DVD. If you want any more, just let me know. I'd be happy to speak about schizophrenia, the DVD or any other aspect that I'm familiar with. Thank you very much for your time.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Marvin. We really appreciate you coming today.

HOPE PLACE CENTRES

The Chair (Mr. Kevin Daniel Flynn): Our next presenter is somebody I know very well, John Challinor from Hope Place Centres, accompanied by a member of the staff. Maybe you can introduce your colleague, John, because we only have your name on the program today. Like everybody else, you've got 15 minutes. You may use it any way you see fit.

Mr. John Challinor II: Thank you, Mr. Chairman. I'd first like to introduce our executive director, Jacqie Shartier, who, in addition to managing our business, will be my subject matter expert this afternoon.

Thank you for the opportunity to appear before you this afternoon to offer our insights related to the development of a comprehensive mental health and addictions strategy in Ontario. As Haldimand-Peel's only residential drug and alcohol treatment facilities, Hope Place Centres and its predecessor organizations have given thousands of Ontarians the chance to get their lives back through their significant presence in the community for more than 34 years.

Despite that considerable effort, one in five Ontarians at some point in their lives will experience a level of alcohol and drug abuse that requires treatment. For 2% to 3% of the province's population, it becomes a chronic problem. Some eventually come into contact with the criminal justice system. Almost all fail to achieve their true potential as contributing members of their communities. Because of alcohol and drug addiction, Ontario is spending billions of dollars annually to address lost productivity, involvement in the legal system, extensive medical care and social services.

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Hope Place Centres fully supports the four goals and seven directions found in Every Door is the Right Door: Towards a 10-Year Mental Health and Addictions Strategy, a discussion paper published in July of this year by the minister's advisory group. However, what follows are seven directions from the board of directors and staff of Hope Place Centres that we also believe are required to help more Ontarians get their lives back:

(1) The government of Ontario should give consideration to developing and delivering ongoing education directed towards students at both the primary and secondary levels of education related to alcohol and drug use. Only through such teaching will young Ontarians come to fully comprehend the consequences of their choice to use drugs and alcohol.

(2) The government of Ontario should give consideration to developing and delivering consistent, ongoing mass communications directed towards all Ontarians regarding the implications of alcohol and drug use. Only through consistent, ongoing messaging will all Ontarians be effectively reminded of the impact of choosing to use drugs and alcohol.

(3) The government of Ontario should give consideration to developing and delivering comprehensive post-secondary education to medical students, including physicians, pharmacists and psychiatrists, regarding alcohol and drug use. Such education should place particular emphasis on providing a level of care that minimizes the prescribing of mood-altering addictive drugs. This training should be complemented by consistent, ongoing communications directed at all practising medical professionals about alcohol and drug use and the life-altering consequences to patients.

(4) The government of Ontario should give consideration to funding ongoing, independent, third party research into drug and alcohol addiction and its relationship to mental health so that more is known about both to inform innovative treatment best practice. Revenues from alcohol and tobacco taxes should be directed away from general revenues and towards alcohol- and drug-related research funding.

(5) The government of Ontario should give consideration to balancing treatment funding of mental health and alcohol and drug addiction, as mental health treatment centres receive more funding today than do alcohol and drug addiction treatment centres. Addiction is a mental health matter. Revenues from alcohol and tobacco taxes

should be directed away from general revenues and towards alcohol- and drug-related treatment funding.

(6) Client treatment: The government of Ontario should give consideration to the following measures, and there are many. You have a copy of them.

(a) Provide base funding for residential treatment service that typically extends beyond 24 days to a minimum of 30 days and a maximum of 90 days.

(b) Provide operating funding for alcohol and drug treatment services within prisons and mental health facilities.

(c) Provide operating funding that enables more timely and frequent drug and alcohol pre- and post-assessment and counselling of clients which addresses both physical and mental health. Such assessment and counselling activity should be expanded so that mental health and addictions workers can visit in homes and institutions to reduce hospital wait times.

(d) Provide full capital funding to residential treatment facilities that wish to expand because they are experiencing growth pressures due to increased substance abuse linked to current socio-economic conditions.

(e) Fund pre- and post-treatment beds in safe and supportive residential environments, such as a withdrawal management centre, which of course Halton doesn't have at this point.

(f) Fund second-stage or post-care housing and beds for recovering clients who are vulnerable because their existing home and/or neighbourhood and/or community environment places them at high risk for relapse.

(g) Fund second-stage or post-care housing for recovering mothers that permits them to care for their children as they progress through their recovery.

(h) Fund recovering mothers and mothers in treatment who require child care support, employment skills training, life skills training, job placement and volunteering opportunities.

(i) Fund day or evening drop-in treatment programs for working Ontarians who are at risk of losing their employment and/or families because of increasingly harmful levels of alcohol and drug abuse.

(7) The government of Ontario should give consideration to providing funding to programs that educate and support families in coping with and/or assisting their loved ones when they are abusing substances, as well as after they have participated in treatment programs.

In closing, the solution isn't just a matter of making a larger financial investment, although more funding is needed. Hope Place Centres believes the long-term solution lies in preventative education, promotion of active individual and family engagement in the treatment process, and support with practical means to make one's way back into mainstream society—a hand up rather than a handout. Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you, John. You've left a lot of time for questions, which is wonderful. We're going to start with either Christine or Sylvia, if you have questions.

Mrs. Christine Elliott: I just have one, just the inter-connection of the mental health aspect with the problems of addiction to drug and alcohol, the kinds of counselling that you provide. A lot of people say that people self-medicate and so on. Do you delve into the underlying mental health issues as well?

Ms. Jacqie Shartier: We have two residential programs, a women-only residential program and a men-only residential program. We have a medical doctor from Credit Valley Hospital who specializes in mental health and addictions, who comes one day a week. We do a pre-assessment of each client who comes in with him to see what their drug use is. He assesses what medication they're on, if they're on the right medication or how long they've been on the medication, consults with their own doctor, if they've had a family doctor, for a history, and works with that family doctor to balance their medication while they're in treatment and to stabilize them.

Mrs. Christine Elliott: Thank you.

The Chair (Mr. Kevin Daniel Flynn): France?

M^{me} France Gélinas: I was happy to see that in your recommendation to be more proactive there is a lot of education. You recommend education for schoolchildren, education for the family, mass media education etc. Are there any best practices or are there any examples out there of which you think, "This is really the way we should do things," or "There's a health unit that really has a good message for kids"?

Mr. John Challinor II: Let me answer that first, France.

M^{me} France Gélinas: Sure.

Mr. John Challinor II: I can't use an example in this particular industry but let me use another one. At one point in this province's history—and some of you may have heard this speech before—Ontario had the best mass recycling education in North America; it was in the 1970s. It reached into the schools, it reached the public in their cars, it reached them when they were at home through television, there was newspaper advertising etc. It extended for about 10 years. The province made a considerable investment in it, and I think that is the kind of structure, from a marketing standpoint, that the government of Ontario needs to consider in drug and alcohol education—mass communications.

Ms. Jacqie Shartier: An example I would like to use is smoking. If you look at 30 years ago and you look at today, the impact of the smoking education on children—children today are telling adults it isn't good to smoke. So children are learning about smoking at a very young age when they go to school. If they learn the impact of what alcohol and drugs have on driving from MADD, I think that is a great example as well.

M^{me} France Gélinas: You also made two recommendations that have to do specifically with mothers and women; that is, to be allowed to mother their children, to care for their children, as well as to broaden outside of addiction counselling to employment skills, life skills, job placement. Is this because of a need or—

Ms. Jacqie Shartier: Yes, it's a need. When you have a woman who is coming to treatment, a lot of women coming to treatment are mandated through CAS and sometimes they have the children, sometimes they don't or they're on the verge of losing their children, so if the treatment programs had access to child care support so the children would be able to have access to their mother while the mother is clean and getting healthy and being well—also, if there was more financial support to provide more of resumé writing, clinical skills, where they could get ongoing support after treatment so that they are not coming from a hostel and going back to a hostel. In a 24-day program, when you take a woman from a hostel and send her back to a hostel, her chances of recovery are very slim.

M^{me} France Gélinas: Okay.

The Chair (Mr. Kevin Daniel Flynn): Thank you, France. Anybody on this side? If not, I have a question, and maybe we can go back to that side.

People talk about a genetic predisposition to addictions. First of all, from your experience, is that true? If your grandfather was an alcoholic and your dad was a drug addict, chances are you're going to be something or you're going to have a predisposition?

Ms. Jacqie Shartier: There is a lot of research on the predisposition to alcoholism and drug addiction. Dr. Gabor Maté has written a lot about this. There are several other doctors who have done the research on this; I could get the links for you. I believe the apple doesn't fall far from the tree. If you look at anyone who has an addiction and go back three generations in their family, usually there is somebody in their family who has an addiction, and if it isn't an addiction, it is usually sexual or physical abuse that has happened at a very young age, and they have masked that pain to deal with it when it happened to them, when they were very young up until they were adults.

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The Chair (Mr. Kevin Daniel Flynn): Okay, then the question I have, before I go back to Liz, is, as part of the treatment for the clients at Hope Place, do you ask them to speak to their kids? Do they tell them, "Look, I had a drug problem, I had an alcohol problem, and you've got a good chance of getting one as well."

Ms. Jacqie Shartier: Well, not only to their children. We have a family worker who's supported by the United Way—and without that support of the United Way funding that family worker, we couldn't help the family. So it is not only to help the children, but it's to help the parents, because the possibility of the addiction has come from the family. So we bring the family in for a full-day education on addiction and what addiction is, and support the children as well, if the children—we don't have a full program for children, which would be an ideal thing to have in place with CAS, to provide that for the children, because I think it is needed for the children as well. Good question.

The Chair (Mr. Kevin Daniel Flynn): Okay, thank you. Liz or Maria?

Mrs. Maria Van Bommel: I just want to carry on a little further with where you started, Kevin, and that is, you talked about—and France talked about it too—your program for mothers in treatment and the idea of having child care and that. What about a program, not just child care in the sense that it's babysitting of the children, but an opportunity to have the children discuss what's happening to them in living in those situations, having them understand what's happening to their mothers and to try and make sure that the family situation changes enough so it's not just mom who gets the treatment, but the whole family has an opportunity to get through this and survive it?

Ms. Jacqie Shartier: That's a perfect example of what is needed in the treatment centres, and I think you won't find that in Ontario, because we're not funded. If we had the funding to support the family, to bring the family in, that is who needs the education to help the whole family.

Mr. John Challinor II: It's recommendation number 7.

The Chair (Mr. Kevin Daniel Flynn): Any other questions? We've got about two or three minutes left, if it has prompted any—let's go to Liz or Helena, whichever.

Mrs. Liz Sandals: I was going to ask about, I guess it's recommendation 6(f) where you're talking about post-treatment care—well, post-treatment housing or beds for recovering clients, because if you send them back into their home environment they're quite likely to fail at their recovery. Is that an issue simply of affordable housing or is that supportive housing? Because there's a difference.

Ms. Jacqie Shartier: I appreciate that question. I know we haven't much time, but if you look at a model in Toronto, the St. Vincent de Paul Society has six post-treatments and they have Ozanam House, which is pre-treatment. You look at the model of that and the success they have with that, that the person waits for up to three months to get into treatment because that's how long we have to wait—three to five months to get into treatment—and then after treatment they go back there and live two years. There's nowhere else in the province that has that model. In the Halton region there is no supportive housing at all for any client waiting to get into treatment or after they leave treatment.

Mrs. Liz Sandals: So it is supportive housing, not simply affordable housing that you're—

Ms. Jacqie Shartier: Yes, supportive housing.

Mrs. Liz Sandals: Okay, thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you. Helena, we've got about a minute.

Ms. Helena Jaczek: Okay. It's somewhat related. You have a very specific recommendation in 6(a), extending the residential treatment from 24 days minimum to a minimum of 30 etc. If you had this sort of post-recovery or second-stage housing, would you also need that extension in the residential treatment program?

Ms. Jacqie Shartier: How we look at this is, from the 24 days for women and the 90 days for men, if somebody

has had a chronic addiction for 10 years, 24 days is a very short time to be able to deal with that person. The advantage we have with the men's program is that we have 90 days for that person to change their life, to get them volunteering in the community, being part of the community. Twenty-four days is very hard to be able to even get housing or supportive housing, any kind of housing, to send that woman back to.

Ms. Helena Jaczek: Do you know the origin of that difference between male and female?

Ms. Jacqie Shartier: I think what happens is in our situation, the government changed the 28-day treatment program several years ago to 21 days. Hope Place kept theirs to 24 days. So all short-term residential treatment programs in the province of Ontario are 21 days. Halton Recovery House, which is the men's program, is funded as a recovery house, not a treatment centre. However, we've changed it to a treatment centre and sold beds to be able to fund it as residential treatment and kept it for 90 days under the recovery model.

Mr. John Challinor II: To further explain, part of our business is funded by the taxpayers of Ontario and part is funded by EAP, so the private sector as well.

Ms. Helena Jaczek: Employee assistance programs?

Interjection.

Mr. John Challinor II: And that's how we're able to fully function. That's how we were able to expand recently.

Ms. Helena Jaczek: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you for coming today, John.

Mr. John Challinor II: Thank you for your time. I very much appreciate it.

The Chair (Mr. Kevin Daniel Flynn): I knew you'd make a wonderful presentation, and you did. Thank you.

JAMES WEBER

The Chair (Mr. Kevin Daniel Flynn): James Weber is our next speaker. James, if you'd come forward and make yourself comfortable. You know the spiel. You've got 15 minutes—

Mr. James Weber: Fifteen minutes—

The Chair (Mr. Kevin Daniel Flynn): Do anything you want with it.

Mr. James Weber: If you can do me a favour, just flag me at 10, in case I'm going too long, and I'll get straight to the point then and we'll leave some time for questions.

The Chair (Mr. Kevin Daniel Flynn): I will do that.

Mr. James Weber: Thank you very much. My name is James Weber. I'm a project manager within wealth management services at RBC, Royal Bank. I currently reside at 115 Omni Drive, Apartment 1202, Toronto, Ontario, near Scarborough Town Centre. The major intersection is Ellesmere Avenue and Brimley Road.

I'd like to thank everyone for allowing me to share my story today. My story starts 22 years ago, when I met my first wife. Approximately six months after we met, we

were engaged. Soon after that she developed her first episode and I discovered that she had a mental illness called schizophrenia. She recovered within a few weeks, after being stabilized on medication. She was fine for the next two years. We were married. She graduated from the early childhood education program at the University of Toronto as a teacher, and all seemed well.

Over the summer that she graduated, it was suggested that she reduce her medication by taking a vacation from the medication, as advised by her psychiatrist, to avoid any buildup and future side effects, so she did. However, as the medication left her body over the next several weeks, the symptoms of the illness started to return. She became paranoid and finally had a full-blown episode. It was fortunate that I was able to obtain medication fairly quickly and have her stabilized.

Once she started to receive medication again, the improvement was evident. However, this time it was not quite as easy. Unfortunately, she had to leave her first job as a teacher within the first week because she was not fully recovered.

The recovery this time was not the same. She was depressed. On Tuesday, October 24, 1989, she called me at work. She wanted permission to kill herself. Her voice had a strange sadness that was not there before. I went home. She was depressed in a way that I had not seen before. She felt hopeless, struggling with the dark vacuum of thoughts that typically race through the minds of people who have schizophrenia.

While I was in the kitchen, she got up from the couch. She said, "Jim, I have to do it," opened the balcony door and rolled over the edge. That was it.

But actually, it was just the beginning. Two days after her passing away, I received an information package from the Schizophrenia Society of Ontario, which was formerly known as the Ontario Friends of Schizophrenics, that I had mailed away for just a few weeks earlier after seeing one of their advertisements in the subway. I opened the package. Inside the package there was a fact sheet and a recommended book list. I read the fact sheet. Three quarters of the way down the page it identified that 40% of people with schizophrenia attempt suicide, and 10% to 15% succeed. Until that moment, no one, including her doctor or psychiatrist, had identified the risk or provided a book list to help me educate myself about the illness. I do ask myself whether events would have been different if I had been more aware.

However, in life you learn that sometimes you cannot change the past but you can impact the present and shape the future, so that's what I did. I ordered the book list recommended by the Schizophrenia Society of Ontario. I contacted the Schizophrenia Society of Ontario. I joined the local East York chapter. I became involved because I wanted to prevent my experience from being repeated. I wanted to educate families so that they could be better prepared.

I quickly learned that the knowledge about the illness was not only in the books or in the brochures but in the people who are part of the organization and who have

seen and experienced it all, some with over 30 years of experience coping with schizophrenia in their families, and not only with one member but sometimes two or three.

Today we're focused on the future. In the past 19 years that I have been involved with the Schizophrenia Society of Ontario, a lot has changed: medications, treatments and information that is much more readily available. However, we still have a way to go.

Some facts: Schizophrenia is a brain disease. Schizophrenia affects one in 100 people. That translates to about 120,000 people here in Toronto and 300,000 in Ontario. The onset for schizophrenia usually is between the ages of 15 and 25. Therefore, the illness has been called "youth's greatest disabler." More hospital beds in Canada are occupied by people with schizophrenia than by people with any other medical illness; schizophrenia represents 8% of the hospital beds in Canada, more than any other diagnosis.

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So it's frustrating to hear family members come into our chapters sharing similar stories of how treatments for mental illness were not there, how the person they finally had admitted into the hospital was released after 72 hours, and the process starts all over again. It's frustrating to hear families say they have to wait until their son reaches rock bottom before they get treatment or are picked up by the police, and how family members were ignored by health care professionals.

I get frustrated reading the newspaper headlines whenever a person with a mental illness, such as schizophrenia, reaches the front page, knowing that if the person had received treatment, the situation may not have occurred. I get frustrated when I walk by people lying on the street at Wellington and York, knowing full well that they probably are there because they have a mental illness and refused to be treated because they are too ill to realize that they are ill. We need to take responsibility for people who can't take care of themselves, yet we seem to continually find an excuse not to do so.

But it's not all gloom and doom. As I mentioned, treatments and services have improved over the past years, and there are some fantastic success stories that I have seen. Here are a few.

Bill MacPhee and the Schizophrenia Digest: In the package I've given you, I've given you a copy of a magazine called Schizophrenia Digest. Bill MacPhee has the illness, and he's more than willing to share his story, so please contact him and ask. He was the editor and founder of that magazine, and it now reaches not only Canada but the US. And he's started a new magazine about depression.

The Bloor Street viaduct suicide barrier: one person every 22 day was jumping off the Bloor Street viaduct, second in North America only to the Golden Gate Bridge in San Francisco, not particularly something you want to see advertised in a tourist brochure for Toronto. However, it took seven years until the proper approvals were received and the financial issues were resolved. Today,

no suicides have since occurred that I'm aware of from the viaduct, and the rate of suicide has declined overall. Contrary to popular belief, people will not always find another place to commit suicide. The act itself can tend to be impulsive. The Bloor Street viaduct has succeeded in removing this risk. However, it took seven years to get everyone to work together. I sometimes wonder, if we had an intersection in the city of Toronto where one person was being killed every 22 days, whether our reaction would have been different.

The Moving Lives Forward Scholarship program: This program is offered by Eli Lilly through their foundation. It is, in my opinion, a wonderful success. The program provides small scholarships within the range of \$500 to \$1,000 to selected applicants who are suffering from a mental illness such as schizophrenia to continue their education. The logistics of the program are done through a charitable organization, like the Schizophrenia Society of Ontario and their volunteers. The success of the scholarship program is not that the money is offered, but it's the fact that receiving the scholarship offers a person with a mental illness a second chance. It shows them that somebody cares and is willing to believe in them. The feedback that I have received has been very positive.

Now, I have three asks for the committee to consider:

(1) We need to find a champion for mental illness. As a project manager, you quickly learn that if a project's going to succeed, a project needs a champion who's going to stand up for the project and protect it from other competing priorities. Projects that don't have a champion fail. Mental illness needs a champion at the provincial level and federal level of government. The champion needs to be supported by all political parties and have the authority to make the changes that are required, and I do believe it can be done.

(2) We stop the revolving door when it comes to treatment of the mentally ill. When a person is sick, we need to treat them as best as we possibly can. We need to stop discharging people after 72 hours. Treatment of a mental illness takes four to six months. We need to improve the handover that takes place once a person is released from hospital and ensure that follow-ups occur—not for a few weeks, but for a few months and possibly a few years afterwards. We need to actively involve families, who are the true 24/7 caregivers.

(3) I would like to see the funding for the Moving Lives Forward Scholarship program, or a similar program, increased. My preference would be \$100,000 per year, either through the Ontario government or other foundations. The scholarship program would be able to offer 100 people a scholarship of \$1,000 to return to school and to help them to start rebuilding their lives. It's amazing how having a second chance can sometimes make the difference to them. The structure of the scholarship program already exists, and only additional funding is required.

Thank you very much for your time today. I did provide some handouts, but I will provide some more, as I understand I didn't bring sufficient. Within the package,

I gave you a copy of the Schizophrenia Digest and a PowerPoint presentation that I present to other groups. Do take a look at the slides at the beginning that provide a 10-question true-and-false quiz.

On a final note, you'll notice in the package I did put a copy of a slide in there where "hope" is in "scHizOPhrEnia." Though we don't particularly like the word, it is nice that you can actually spell "hope" out of the word "schizophrenia."

As for myself, I'm going to continue to be an active member of the Schizophrenia Society of Ontario, providing families a reason to hope and the means to cope. If by chance you are in the neighbourhood of Metro Hall on Sunday, May 30, 2010, I invite you to drop by for the Walk of Hope for Schizophrenia and come and meet some of the families who are working together to make change happen.

The Chair (Mr. Kevin Daniel Flynn): That was pretty good. You didn't even hit 10 minutes—9:52.

Mr. James Weber: There we go. Toastmasters does work.

The Chair (Mr. Kevin Daniel Flynn): Let's start with France. We've got about six minutes.

M^{me} France Gélinas: Thank you for your presentation. I'm sorry about what happened to your wife.

The idea that we should do more for people who refuse treatment is one that we have heard a number of times. Have you thought this thing out, and can you elaborate as to what would be the trigger from now on as to, "We will treat you whether you want us to or not?"

Mr. James Weber: Let me put this in the context of what I had to deal with with my wife. One, she reacted very well to her medication. Typically, if she was on her medication, you would not be able to tell that she was actually ill. I'm sure to this day that several of her friends don't even realize that she had a mental illness such as schizophrenia. But when she became ill, she actually refused her medication. It would reach the point where she could not eat or sleep or settle down. We'd literally have to corner her in such a way as to make sure we could get an injection into her to get the medication straight into her bloodstream. Once that was done, she started to realize what was going on. She would actually realize that she had fallen into another episode and she'd start to recover.

Now, a lot of people aren't that fortunate. She was good on the medication. Other people don't react the same way. Once a person is unable to feed themselves, can't take care of themselves—and it's not fair to point out, but with people on the street, typically you can tell they haven't been able to take care of themselves in a while. Then you've got to ask the question of whether or not they are mentally ill and whether or not they really need to be treated. I understand it comes to the point of rights, but then again we have to look at the other side: Do they truly understand how sick they are in that respect?

I can only tell you from my experience that once I got the medication into my wife, she realized she was ill, she

recovered, and she became much better. In the time that I knew her, she went on to get a degree in early childhood education, and if all things had worked out, she possibly could have been a teacher, but that's the way it goes.

I get frustrated by the fact that we have a tendency of leaving people on the street, hoping they're going to fend for themselves. They're going to survive, but it's not a life that I would particularly want to lead.

The Chair (Mr. Kevin Daniel Flynn): Thank you, James. Let's move on. Liz?

Mrs. Liz Sandals: Thank you very much for sharing your experience with your wife. From what you've just said, in the case of your wife you obviously had access to the drug to try and get the drug into her. What I often hear from families of schizophrenics in my office is possibly one more step removed, where the person isn't necessarily living with the family but has close contact with the family. The family begins to see the signs that they're off medications. They know, but nobody will pay any attention to them. Either the police will say, "But they're not a harm to anybody. They're not a danger yet," or the medical profession will say, "But we can't talk to you," the family. It's confidentiality. In both of those cases there's tremendous frustration. The family knows what's going on but has no capacity to do anything about it.

Do you have suggestions about what you would change to deal with that situation?

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Mr. James Weber: I know it's difficult to put in legislation, but common sense has to prevail. When you do see somebody who's unable to feed themselves and the family is indicating to you that they are not helping themselves, that they are heading towards the bottom, then we should allow ourselves the right to step in. I understand that we need to protect the rights of people, but at a certain point, too, we're actually abdicating our responsibility to treat people who do need treatment.

Typically, family members—and you can tell, if a family's fairly stable. If they see somebody with a mental illness degrading, if we could simply apply the common sense that goes with it and step in, figure out what the situation is like and try to determine what's going on, then I think we'd start to see that the family is correct in terms of the person being seriously ill.

When I say step in, I'm not talking a one-hour interview, because typically people with a mental illness like schizophrenia—my wife could hide it for an hour. It's more in being with the person 24 hours a day, seven days a week, that you start to see the symptoms come out. They can't hide it forever, and that's where you see the problems.

The Chair (Mr. Kevin Daniel Flynn): Thank you, James. We have to move on. We've just got one short question, perhaps, from Sylvia.

Ms. Sylvia Jones: Hi, Mr. Weber. Thank you for your presentation. I wanted to continue on the compulsory treatment theme.

In your work with the Schizophrenia Society, are you familiar with jurisdictions where they have dealt well, in

your opinion, on involving the family and on treatment when it's being refused?

Mr. James Weber: To be honest, I'm not aware of it myself. I hear of programs; I hear people coming into our chapter talking about various programs that seem to work, but I can't point out a specific area or region that's doing it extremely well at this point in time. It seems to be pockets of success without integration that's sort of linking them all together.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today, James. We appreciate your presentation.

Mr. James Weber: Thank you very much.

ALLIANCE OF PSYCHOTHERAPY TRAINING INSTITUTIONS

The Chair (Mr. Kevin Daniel Flynn): Our next presenters today are from the Alliance of Psychotherapy Training Institutions: Linda Page and Sharon MacIsaac McKenna. If you'd like to come forward and make yourselves comfortable.

Ms. Linda Page: Good afternoon.

The Chair (Mr. Kevin Daniel Flynn): Good afternoon.

Ms. Linda Page: We appreciate the chance to come and talk with you. Sharon and I are both involved in the Alliance of Psychotherapy Training Institutions. We each work in our own institution. In general, I want to talk with you today about what we teach, which is psychotherapy, so it's kind of a different level of discussion that I'll be talking about.

I have given you a written report that will be different from what I'm saying to you. The points are pretty much the same, but I'll describe it in a different order.

The alliance is made up of 21 psychotherapy training institutions that have existed in the province of Ontario for many, many years. Altogether, we probably have thousands of hours of teaching and have touched the lives of nearly every psychotherapist in Ontario in one way or another, whether they are practising as doctors, social workers, independent psychotherapists, in the ministry or whatever, because so many of the professionals come and train with us.

I want to start off by talking about my own experience and that of other psychotherapists when we're at a dinner party or a family gathering—actually, when I'm somewhere where people don't know me very well. They'll say, "So, what do you do, Linda?" and I'll say, "Oh, I'm a psychotherapist," and there's a pall that comes; there's a silence, and, "Um, um..." I think part of that is—

The Chair (Mr. Kevin Daniel Flynn): Try telling them you're a politician.

Laughter.

Ms. Linda Page: Is that even worse? My condolences.

I think the reason for this kind of stop in conversation is—several reasons. One is that people are embarrassed if they themselves suffer from the stigma of mental illness

or if some of the people they are close to do. However, I think another reason is that people don't know what psychotherapy is. For most people, psychotherapy, psychiatry, psychology, and anything else that starts with a p-s-y is pretty much all the same thing, so they're not quite sure what it is you do.

I think that's a big reason for the silence, that people don't know what to say. They don't know what to ask you. I mean, if you're a plumber, they say, "Well, gee, can you come fix my pipes?" but they're a little bit more reluctant to say, "Can you come and treat my schizophrenia?" or whatever.

So what I'd like to do today is explore the advantage of the fact that there is so much variation in psychotherapy, talk about the challenge that comes from that variation and give you an example of APTI, which I believe shows a collaborative example for both extracting the strengths and overcoming the weaknesses of the great variability that we find in psychotherapy. Basically, I hope this will prove useful to you as you consider how to apply resources so that the people of Ontario can receive better mental health services.

As I say, psychotherapy is very variable. If you are a client of a therapist—and when I say "psychotherapist," I mean clinical counsellor, psychiatrist, anyone who provides what is defined in the new Psychotherapy Act as psychotherapy. Clients may say, "Well, I'm in psychotherapy and what I do is I sit and I talk with my therapist." Somebody else says, "Well, all we do is draw pictures," and somebody else says, "Well, I dance," and somebody else says, "Well, we sit and meditate." So the experience of clients is very different. Therapists might be trained as medical doctors, as pastors, as social workers, as counsellors or additions counsellors. Until recently in Ontario, of course, there was no single standard for psychotherapy, so that there was nothing in legislation that you could point to say that says, "Okay, here's a definition of psychotherapy." In fact, even the scientific community around us has questioned what is psychotherapy and does it work. For a while there was an argument that you're better off leaving people alone than giving them psychotherapy; they'll recover just as well. We now know that's not the case, but there was that argument. And for whom does it work and, if it works, what is it that does the working? So all kinds of variations and arguments and contention have been the case in psychotherapy.

This can be a strength. There are many modalities of psychotherapy and that is a strength. If you think of Tolstoy, there's a phrase in Anna Karenina about happy families being pretty much the same but unhappy families are different in many ways. But the fact is that unhappiness, the suffering that comes from mental illness and additions, comes in very many flavours. So it's important to protect the variability within psychotherapy services so that the different kinds of suffering can be treated in ways that suit those many different needs.

However, this variability, I think, contributes to things like dinner party confusion, which is not the biggest

problem, of course, but confusion about what psychotherapy is and what it can do. We in APTI have sought to look at what is an underlying connection, a commonality among the different forms of psychotherapy. Science has aided us in this search. Over the last three decades some very rigorous research has been done—you've probably heard about it—that has identified that no matter what kind of psychotherapy is being offered, there are basically underlying it four things that account for effectiveness or efficacy in psychotherapy. One of them is the psychotherapy relationship, which is part of the definition of psychotherapy in the Psychotherapy Act, that that's treatment provided through a relationship. About something like 30% of the variability in improvement in psychotherapy comes from the quality of the relationship, only 15% from the kind of technique you use and 15% from placebo effect. The other 40% has to do with the characteristics of the client or the patient. So that again underlines how important it is to have a variety of treatment modalities available, given the variety of issues that exist and types of individual issues that exist in mental illness and addictions.

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Science says that underneath all these different variations there is a commonality, but right here in Ontario we have another example, and that's APTI itself. In the lead-up to the change in the health act that produced the Psychotherapy Act, we in the various organizations that have come to form APTI looked at each other and said, "You know something? We know what psychotherapy is. We teach it to people all the time. When we speak to each other, there is a commonality, so surely we can arrive at a curriculum that we all agree on as a kind of common basis." Then you can go off from that and study the specific modalities, whether it's psychoanalysis, emotion-based therapy, cognitive-behavioural or relation-based therapy—right?—a relational system, self-psychology, all those different approaches.

Surprisingly, given the contentious history of psychotherapy, these 21 institutions came up with a common curriculum where we all said, "Yes, this is what we agree on is necessary as a foundation for a psychotherapist to be able to practise." Then we did something else which I think is very notable, and that is that we said, "And there are guidelines that we can follow for our own individual types of psychotherapy." For example, in my school we teach Adlerian therapy, and in that approach I need to follow the guideline of providing a history of how that developed, an explanation for how people become mentally ill from that perspective, what treatment means and how it occurs and all those things. So those guidelines I think are very important.

I'm offering this to you as a sign of hope in the potential for the psychotherapy community to come together and collaborate and work across professions, because this is one area where there's one profession which is practised by many professions; that is to say doctors, social workers, people who identify primarily as psychotherapists, psychiatric nurses, occupational therapists and

psychologists. These are the people who are allowed to practise psychotherapy under the new Psychotherapy Act. We stand as examples that it is possible for us to collaborate across those professions, and we see as a next step then to invite academic institutions to examine what it is that we see as the common basis, the common foundation to provide psychotherapy education for incoming psychotherapists.

As I say, psychotherapy is variable. That's a strength that must be preserved, and yet there's also a need to identify the underlying unity within a profession that has been quite disintegrated over the years.

I think in order to be more efficient in providing services to the people of Ontario, we need to come together. I'm glad to say I didn't believe that this was possible when we first started talking at APTI, but the collaboration that we have achieved I think is really quite remarkable. We offer that not only as an example of what's possible within the psychotherapy community, but we also offer APTI as a place that pulls together much of the knowledge about what psychotherapy is and what it can do. So we offer that as a resource to this committee. Of course, as we understand better what the commonalities are within psychotherapy, perhaps that will not only improve mental health and addictions counselling and therapy in Ontario but might even improve dinner conversations.

There are several discussion points that we mention in the paper that I've provided for you. I think my colleague Sharon MacIsaac McKenna has a couple of comments to make about that.

The Chair (Mr. Kevin Daniel Flynn): We've got about a minute left.

Ms. Linda Page: Oh my God, I took that long. I'm so sorry.

The Chair (Mr. Kevin Daniel Flynn): How good are you at summarizing?

Ms. Sharon MacIsaac McKenna: I would suggest that you really study this and absorb it, because psychotherapy is new on the health services scene. It's actually a health service and it's outside of health service; it's in the spiritual realm if you look at the institutions involved. Those are what the forms of psychotherapy are in the province and internationally; these are all international. You might be surprised to find that something like the sand play therapy is very, very congenial to the native community. They're asking for it. Hincks-Dellcrest institute is involved in working with dreams with them.

Psychotherapy is about human life. It's indicated in here that states like anxiety and depression are normal. They're often realistic. They follow loss of jobs, loss of income and they follow divorce—the tendency in the health service is to talk about them as pathological. Where pathology will then have them hit medical records, there's going to be a problem, and I've indicated this here.

One of the big problems is that people avoid diagnosis because they know that they're going to pull through or they've got to find other means. I can only invite you to

have us talk to you. It's so big a field; it's over 100 years old. As Linda said, it brings together such disparate streams, so many disciplines. There is a Buddhist outreach, there are all kinds of body therapy, there's yoga and meditation, and it sounds like just a bag of tricks, but it's actually a profound presence to one's own life and it's restoring to each person the capacities to live their own life. Whether they're on medication, whether they're addicted, that's the psychotherapy presence. That's what distinguishes it. It's basically relational but it needs lots of training and lots of modality.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for your presentation. The report is very thorough. I'm sure that all members will pay some attention to it.

Ms. Linda Page: Thanks a lot.

The Chair (Mr. Kevin Daniel Flynn): Thank you for coming today. It was really appreciated.

PATRICIA TESKEY

The Chair (Mr. Kevin Daniel Flynn): Our next speaker today is Patricia Teskey; Patricia, if you'd like to come forward and make yourself comfortable. You have 15 minutes, like everybody else. Use it any way you see fit. At the end, maybe there will be some time for questions.

Ms. Patricia Teskey: Thank you for this opportunity to speak to you today. I'm a mom. My son became ill with schizophrenia and experienced his first psychotic break in 1996 at the age of 23. I have some recommendations about early intervention, but I would like to begin by sharing some reflections and observations.

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A few years ago, I attended an event where the guest speaker was Heather Stuart, a researcher at Queen's University, I think. She said that when agencies receive funding with a mandate to meet the needs of the very seriously ill, it's common to find, before too long, that they have given up on the difficult people and have gravitated to people who are easier to serve. We need to protect money targeted for people with serious mental illnesses. We need to promote healthy approaches to life's challenges, such as being laid off from your job, but new money should be found for that. The money should not come by cutting psychiatric beds to the acute care mental health units of our community hospitals.

Both the Mental Health Commission of Canada and the Schizophrenia Society of Canada are asking us to reject the so-called biomedical model or message and to embrace the so-called recovery model or message. With all due respect, neither of these organizations needs you or I to be their cheerleaders. They need our honest evaluation and feedback. Both the recovery and biological models have inspiring contributions; however, both have serious flaws, and choosing one over the other will only add to the grief and suffering of people with serious mental illness and their families.

Family caregivers, imperfect as we are, are the default mental health system for both models. We need to be free to cherry-pick the best of any model, concept or idea that comes along.

The recovery model inspires us to envision even the most ill as having the potential to recover a meaningful life, and that is truly wonderful. However, the recovery model seriously fails the many people who are like my son was when he was floridly psychotic and not well enough to make an informed choice.

For most people in a psychotic state, the part of the brain that enables the person to have insight or self-awareness is not functioning. The person has anosognosia, a Greek medical term. In English it means "to not know that you are ill." Yet the recovery model insists that our highest value must always be the ill person's right to choice. How can that be the highest, most compassionate or ethical value when the person is suffering from mental impairment and can't make an informed choice? Some people argue for letting a person go ahead and make a poor choice: That's okay, because they will learn from the consequences and maybe make a better choice next time. But that is playing Russian roulette with the person's life. There might not be a next time.

A mom and dad that I know sought to have their 25-year-old daughter found incapable at a consent and capacity review hearing. They wanted her to be involuntarily detained in hospital because she was suicidal. The patients' advocacy office defended her choice to leave the hospital, and won. So she left, jumped off a bridge and died. The patients' advocacy office didn't even send a card. It was the family that was left to literally pick up the pieces.

As long as a person thinks they're not ill, they won't ask for help. Why would they? And if they don't seek help, they will continue to be ill. This dilemma is so common, it is called the Catch-22 of schizophrenia. The longer a person remains in a psychotic state, the more cognitive damage occurs, and the longer it takes to stabilize once medications are started. So the recovery model, or message, becomes relevant only after a person is stabilized and their insight is restored. They now need choices and opportunities for recovering a meaningful life.

I believe the most efficient and humane path through this psychosis to readiness for recovery is through early intervention. However, early intervention is still largely unavailable. Even in the greater Toronto area, population about four million, there are only a handful of first-episode clinics.

We're told to get help early, but what happens when you go for help early to your family doctor or your local community hospital? I invite you to look through a parent's eyes at what happened to my boy. He was 23 years old and just six credits shy of graduation from university when he had his first psychotic break. Initially, he had insight into what was happening to him. When I asked him to explain his sudden bizarre behaviour, he said, "I have paranoid schizophrenia." This would have

been the optimal time for early intervention, but it was to be four years before he was stabilized on medications.

I phoned his family doctor, who said, "I don't do psychiatry." He didn't refer him to a psychiatrist. He said, "If he's psychotic, take him to emergency." My son and I went together to our community hospital. The psychiatrist there gave him old medications and sent us home. My son stopped taking the medications. Within four months, he was so psychotic that the hospital finally admitted him. He went willingly. He wanted help. But after four weeks, the newer medication still hadn't stabilized him. He was discharged in a psychotic state.

That was the first of eight hospital admissions in less than four years. My son became a revolving-door patient because the hospital kept discharging him too early—when he had just started to stabilize, but before he had reached a fully stable state. He deteriorated, dropped out of university. He lost his friends, and he now didn't know that he was sick. He thought people were poisoning his medication, so he was afraid to take them. He was terrorized by constant threatening voices and begged me to help him. I tried to help him.

There were three involuntary hospital admissions, all requiring a form 2 from the justice of the peace and a police escort. There was a consent and capacity hearing that found him incapable and allowed for him to be given medications involuntarily. However, the hospital still discharged him before he was stabilized and without support for staying on the meds.

Finally, in 2000, a psychiatrist agreed to detain my son in hospital until he was stabilized. My son came out of the psychotic state and his insight was restored. It took nine weeks. Fortunately, this hospital had just acquired an assertive community treatment team. As part of my son's discharge plan, he agreed to work with the ACT team to stay on the medications.

But the real miracle came two weeks after discharge: 11 weeks after starting the medications, they finally clicked in. The delusions and paranoia disappeared like night and day. I came home from work to find him phoning his cousins and friends. He got his relationships back. Then he phoned his former employer and got his part-time job back. That was nine years ago. He has never had to go back to the hospital. He returned to university and graduated in 2006. He is now working part-time.

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And, I want to add, after he was stabilized my son did not resent me or the doctor who detained him in hospital and treated him involuntarily. On my next birthday he gave me a beautiful card. It said, "To mom, with gratitude. Thank you for everything you have done for me."

I'm grateful too, but I wish that he had received early intervention at the time of his first psychotic break. He would have been spared years of suffering and torment. And for those who care about the cost, the mental health system would have been spared huge expense.

In our community hospital I believe there are plans for an early intervention program, but it will be restricted to

adolescents up to age 17. But what about the many young people who have their first psychotic break between ages 18 and 30? My son had his first episode at age 23. Age cut-offs for early intervention should be recognized as discrimination on the basis of age. Can you imagine telling someone with the first signs of cancer that they can't receive early intervention because they're over the age of 17, or 34, or 46? It is double discrimination against females, who often have their first psychotic break at a later age, in their late 20s or 30s.

So my recommendations to the select committee are:

(1) That the mental health units of every community hospital in Ontario be mandated, funded and required to follow the best practices of early intervention as the norm with every patient, with no age or gender restrictions;

(2) That instead of a discharge plan, mental health units in community hospitals design a wellness or recovery plan with each individual, where discharge from hospital is just one point on a continuum of support and opportunity in the community; and

(3) That funding be allocated for more ACT teams to support people after discharge from hospital.

Thank you.

The Chair (Mr. Kevin Daniel Flynn): That's wonderful. You've left us about a minute and a half for maybe one question. I think we're on this side now. Lorenzo.

Mr. Lorenzo Berardinetti: First of all, it's very brave of you to come forward with your story, so I want to thank you for sharing that with us.

More than a question: This issue about—and I'm only subbing for today, so I'm only here for today's session, but I wanted to know, and maybe the researcher could find out for us, what the rights of an individual are and at what point a doctor or a health care provider can step in to help someone or intervene, because I think the problem that we see again and again, and we've seen with this deputant today, is that people who have episodes are allowed to continue to make decisions. I think there has to be some—I guess the doctors out there are aware of some kind of law that doesn't allow them to hold these people—

Ms. Patricia Teskey: The Mental Health Act does allow for somebody to be treated involuntarily if they are in danger or a danger to someone else or—I think in Ontario; I know in BC, maybe in Ontario—if they are markedly deteriorating.

Mr. Lorenzo Berardinetti: Who makes that decision?

Ms. Patricia Teskey: I had to go to a Consent and Capacity Review Board; I went to two of them. And it's very important that the family member be allowed to be there. Some other people—the lawyer for the client doesn't often want that because the family has essential information that the review board needs to hear. But most people don't make it that far through the system because access to get into the hospital in the first place, to get a doctor—anybody who makes it all the way through to a Consent and Capacity Board is really sick. People complain that in only 3% of cases the client wins. Well,

that's because most people who really should be at a Consent and Capacity Review Board never make it anywhere near there. You have to be pretty sick—and the doctors, it's no fun for them and they're busy.

Mr. Lorenzo Berardinetti: Yes. So I guess the question would be, how do we make it easier without creating more bureaucracy? Nobody wants more bureaucracy, but how do we make it easier to get to that point where intervention can take place?

The Chair (Mr. Kevin Daniel Flynn): The next presentation may shed a little more light on this issue as well. So thank you for your answers and for your presentation today. Thank you very much for coming.

Ms. Patricia Teskey: You're welcome.

PSYCHIATRIC PATIENT ADVOCATE OFFICE

The Chair (Mr. Kevin Daniel Flynn): Our next presenter is the Psychiatric Patient Advocate Office, Vahe Kehyayan and Ryan Fritsch. Was that last presentation a good segue for your presentation?

Mr. Vahe Kehyayan: It is indeed.

The Chair (Mr. Kevin Daniel Flynn): That's what I thought.

Mr. Vahe Kehyayan: Can I take my jacket off?

The Chair (Mr. Kevin Daniel Flynn): Oh, yeah; I've had mine off all day. It's a little hot in here. It was freezing this morning.

You've been here for a few of the presentations, so it's exactly the same. You get 15 minutes. Use it any way you like, and maybe leave some time at the end for some questions and answers, if possible.

Mr. Vahe Kehyayan: Before I begin, I'd like to acknowledge the passionate message of the previous speaker. I think, coming from the heart of a mom, it's very important, so it really makes my own presentation, in terms of importance, relative to that message.

Good afternoon, Mr. Chairman and committee members. I'm Vahe Kehyayan, director of the Psychiatric Patient Advocate Office. With me is Ryan Fritsch, our legal counsel. We are very pleased to appear before the committee and thank you for your invitation.

The PPAO began more than 25 years ago to protect and uphold the legal and civil rights of inpatients of the provincial psychiatric hospitals in Ontario. We are here today in support of a formally established and provincially coordinated mental health advocacy mechanism as an essential and integral component of a comprehensive mental health system.

Last year, our 12 patient advocates responded to over 3,700 individual issues. One third of these issues related to quality of care and quality of life. Over half of the issues were related to legal matters, especially access to justice. The remaining 15% of our advocacy services related to social entitlements and programs. We also provided mandatory rights advice under the Mental Health Act in over 22,000 cases within the community and provincial psychiatric facilities. More information

about our office and our activities is detailed in our 2008-09 annual report, which we sent to the committee members last month.

Our activities represent just a fraction of the need for mental health advocacy across Ontario. While we currently provide advocacy in 10 specialty psychiatric facilities, there are more than 55 psychiatric units in general hospitals across Ontario where consumers have no access to advocacy services. In addition, many treatment, rehabilitation and support services have now migrated from hospital to community, and the vast majority of those individuals who live with mental illness reside in the community and receive services there. However, for these individuals, access to advocacy services is limited or non-existent. In our view, advocacy services should be available to all Ontarians with mental illness, regardless of where they live or where they receive their services or treatment.

Our focus since the inception of our program in 1983 has been to strengthen the voices of those we serve and to support their ability to make decisions about their own care, treatment and lives. The ability to make decisions about the things which most affect us is fundamental to our rights as human beings and our membership in a democratic society. Because of stigma and discrimination, persons with mental illness may never fully enjoy the benefits and opportunities to which most citizens are entitled.

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In our 25 years of experience, we have developed a much deeper understanding of what it means to be socially marginalized, stigmatized, and economically disadvantaged as the result of mental illness. We now know how living in poverty, joblessness, homelessness, substandard housing and the absence of equitable access to resources and opportunities—and early intervention, as a previous speaker talked about—can directly and negatively impact physical and mental health. These are not only the potential social consequences of mental illness, but often determine its course and outcome.

Advocacy has the power to mitigate the negative social impacts of mental illness through its work with individual consumers and the service delivery and support systems at large. In this way, advocacy is both a front-line resource and a fulcrum for social change at the systems level. Our ambition as advocates is to put people in control of their own mental health care and lives. We may be striving to create a client-centred system of care, but our greatest challenge is how to harness the expertise of the client as a source of change. Advocates help foster a collaborative approach to care that respects rights while facilitating self-defined recovery. This creates a more responsive, effective and comprehensive mental health system.

These considerations respecting the role and importance of advocacy lead us to believe that formal, independent advocacy services must be strengthened. As the mental health system continues to undergo modernization and refinement, so too must the delivery of mental health advocacy services.

In order to achieve effective advocacy in Ontario, we believe that we must take the following steps:

(1) We must ensure that advocacy has both the mandate and the resources to be fully independent. It must be provided free of any interference from institutions or service providers and from any perception of bias or conflict of interest. Effective advocacy also requires the ability to work across systems like health, law and social services. Advocates cannot provide such services if they are tied to a particular institution or program or clinical service that may be mandated to work from the standpoint of best interests.

(2) We must ensure that advocates have a formally established and fully recognized role throughout the mental health system. When the PPAO was established in 1983, we were the first patient advocacy program in Canada. Today, Ontario is falling behind other jurisdictions like the United Kingdom, where legislation mandates the availability of advocacy services at any point in the mental health system. These jurisdictions have recognized the importance and value of professionalized advocacy services provided by formally trained advocates. A legislative mandate would give advocates the authority to do their job more effectively and would allow for the creation of coordinated province-wide advocacy services. Such oversight is a particularly important role in a fractured mental health system delivered through a variety of health and social support providers.

(3) We must ensure that provincial advocacy services have a modern governance model that supports stronger accountability, transparency, and more responsive service delivery. We believe that formal advocacy services are just one in a plurality of consumer advocacy opportunities that includes peer support, family members and public interest groups. Governance of a provincial advocacy service should represent that diversity. It should be a way to enhance and improve coordination to identify common issues, incorporate consumer and stakeholder feedback, and evaluate remedies and strategies. It should also help foster the development of local community resources where none exist or resources are limited.

(4) The final point: We must develop advocacy resources that keep pace with the migration of services into the community and that are fully accessible across facility-based and community settings throughout Ontario.

In summary, our vision of a comprehensive mental health system hinges on the inclusion of advocacy as an integral component to assist consumers in taking greater charge of their own mental health care and lives. Advocacy services that are provided seamlessly throughout the mental health system are of benefit to individuals, service providers and policy-makers. For individuals, advocacy provides a means to realize a truly client-centred mental health system that maximizes the consumer voice in matters that affect their care, treatment and quality of life. For service providers, advocates provide early identification and resolution of consumer concerns and are a professional resource on mental health

law and rights. For policy-makers, advocates provide a province-wide perspective on systemic barriers and service delivery from the consumer perspective, improving risk management and balancing operational needs against the rights of the vulnerable. The further development of a fully accessible, province-wide, independent advocacy service will pay substantial dividends in consumer recovery and wellness and the overall effectiveness of our mental health system.

In closing, we wish to thank you for the opportunity to appear before you, and we hope that you will give serious consideration to the realization of our vision. Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you. We do have some time, then, for questions. Let's start with either Christine or Sylvia.

Mrs. Christine Elliott: Thank you very much for coming forward with your presentation today, because I think it really is critical that we hear from your organization. Some presenters—you may have heard some of them today—take the position that the Psychiatric Patient Advocate Office is sort of furthering the rights of people who may not have the ability to make their own decisions. But I think it's a question of balancing the roles and responsibilities, and I certainly see your office as an important part of that balance, because there are many situations where people's rights do need to be brought forward.

But I would just be interested in your comments as to what you would say to the parents who are saying, "There's no way for us to get help." What would you see as a necessary change in order to achieve that balance between civil liberties and the rights of parents and families and of the individual where they may not have the capacity to make their own decisions in a careful, thoughtful way?

Mr. Vahe Kehyayan: That's a good question, a very good question indeed. It's difficult to answer, though. We do agree on the balance in the system.

Our program really brings forward the voice of the consumer and client. We bring that concern or voice to the treatment team, and we raise the issues from the client's perspective. Sometimes the quality-of-care issue could be that the medication that they are receiving is not helpful, and the patient is complaining about the side effects and whatever, yet that treatment approach is not being changed, so the client comes to the patient advocate and says, "Could you help me with this issue?" Really, the patient advocate becomes the facilitator in that dialogue with the treatment team so that the treatment team sees a different perspective. Many times, the treatment approach—the medication, for example—is changed, and the patient benefits from that.

We also appreciate sometimes that there's a conflict between a family's perspective and the client's, as our previous speaker raised, and we also appreciate that concern. But, again, in our society, we respect people's choices and the need to make decisions about their own lives, to self-determine what happens to them. Within the

framework of the mental health legislation, the advocate brings that voice forward.

The Chair (Mr. Kevin Daniel Flynn): Thank you. It's time to move on. France?

M^{me} France Gélinas: I guess we've heard enough people come and talk to us, especially with schizophrenia and severe mental illness, where it comes to a point that it's almost part of their disease that they refuse treatment and suffer horrendous consequences for it, to the point where one is left to believe that all of the seriously ill that we see as homeless have lost their right to treatment. We've kind of lost the balance, where the right to treatment lost out to the right to civil liberty. The fact that you lost your right to treatment means horrible consequences for those people. If your vision was to be realized, would it have an impact on what we see?

Mr. Vahe Kehyayan: Well, part of our vision is that our advocacy, which right now is restricted to the 10 former provincial psych hospitals, is available to all patients in all settings, including in the community. If we feel that patients have some sense of protection within the walls of a hospital, you can imagine that those who are out there in the community, and that's the majority of them, do not have those protections—the homeless, etc.

On early intervention, which our previous speaker spoke about, many of our clients, or those who are in the community, have difficulty navigating the health care system or the health and social service system.

I don't know about you, but sometimes, I, as someone working in the ministry—many of our extended families come to me as their advocate and say, "Help us connect to the right service." I have difficulty helping them, so imagine the vulnerable individual who has a mental illness and who's out there in the community and is unable to navigate. One of the roles that we see for advocates in the community is to help these individuals connect to the right source at the right time before some serious harm comes to them.

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Again, your question is related to the earlier question in terms of how we balance that. The advocates really do not have any authority or power about the treatment. All they do is bring forward the issue to the treatment team's attention so that they reconsider the decision that they have made.

The Chair (Mr. Kevin Daniel Flynn): Okay. We're going to have to move on. We've got about a minute and a half left. Does anybody have a question on the government side? Liz or Maria, whoever.

Mrs. Maria Van Bommel: I'd just like to carry on with the whole idea. You talked about the need to be able to make decisions and to have choices and make those for the client. I think we've heard repeatedly in the number of hearings that we've had that there are very often consequences, and France talked about horrific consequences for the patients themselves, but for the families, too, who are essentially going along and trying to do remediation for things that have happened that their family member has done in the community, and that sort

of thing. They're constantly going along and they're asking to have some opportunity to have treatment and medications essentially enforced. You're saying as an advocate your job is to allow the choice and to allow the patient to make their own decisions and to make their own choices. How do you reconcile the needs of society and the family and the needs of the patient?

Mr. Vahe Kehyayan: We think that our Mental Health Act, the mental health legislation, is very well thought out and was debated before committees many years ago, and it does provide a framework. It does have a balance, and people do exercise their choice. Again, there is a framework: Where there is a risk to the individual, whether it is self-harm or harm to society or to others, there are mechanisms in the act itself so that the person receives treatment at the right time so that harm does not occur.

Just to clarify, when you say what the advocate's actions are, we only take the voice of our client to the treatment team. Our value system is that we respect choice, yet we help the individual to bring that concern to the treatment team—it could be the physician, or it could be the multidisciplinary team—so that the decision is made.

Many times, the reality is also that many of our patients who are in the provincial psych hospitals or the divested ones do not have family members, or they may have family but they are in other cities, towns or provinces or even out of the country, and it is very difficult. In our rights advice situation, we come across family members who are away from Ontario, and we have difficulty connecting with them when there is rights advice to be provided.

The Chair (Mr. Kevin Daniel Flynn): Thank you. I'm going to have to jump in there, unfortunately. We did want to hear the answer, but we're starting to run out of time. Thank you very much for your presentation. It was really appreciated.

Mr. Vahe Kehyayan: Thank you.

PAUL CASOLA

ADRIANNE SEQUEIRA

The Chair (Mr. Kevin Daniel Flynn): Our last presenter of the day before we head off to Ottawa is Dr. Paul Casola.

Ms. Adrienne Sequeira: I'm afraid he's not here yet.

The Chair (Mr. Kevin Daniel Flynn): You must be Adrienne.

Ms. Adrienne Sequeira: I am.

The Chair (Mr. Kevin Daniel Flynn): You don't look like a Paul. Make yourself comfortable then, Adrienne, and we're all yours for the next 15 minutes.

Ms. Adrienne Sequeira: I think Dr. Casola must still be on the road. Oh, he's right here. Great. Good timing.

The Chair (Mr. Kevin Daniel Flynn): Okay, we're all yours.

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In closing, we wish to thank you for the opportunity to appear before you, and we hope that you will give serious consideration to the realization of our vision. Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you. We do have some time, then, for questions. Let's start with either Christine or Sylvia.

Mrs. Christine Elliott: Thank you very much for coming forward with your presentation today, because I think it really is critical that we hear from your organization. Some presenters—you may have heard some of them today—take the position that the Psychiatric Patient Advocate Office is sort of furthering the rights of people who may not have the ability to make their own decisions. But I think it's a question of balancing the roles and responsibilities, and I certainly see your office as an important part of that balance, because there are many situations where people's rights do need to be brought forward.

But I would just be interested in your comments as to what you would say to the parents who are saying, "There's no way for us to get help." What would you see as a necessary change in order to achieve that balance between civil liberties and the rights of parents and families and of the individual where they may not have the capacity to make their own decisions in a careful, thoughtful way?

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The Chair (Mr. Kevin Daniel Flynn): Okay. We're going to have to move on. We've got about a minute and a half left. Does anybody have a question on the government side? Liz or Maria, whoever.

Mrs. Maria Van Bommel: I'd just like to carry on with the whole idea. You talked about the need to be able to make decisions and to have choices and make those for the client. I think we've heard repeatedly in the number of hearings that we've had that there are very often consequences, and France talked about horrific consequences for the patients themselves, but for the families, too, who are essentially going along and trying to do remediation for things that have happened that their family member has done in the community, and that sort

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The Chair (Mr. Kevin Daniel Flynn): Thank you. I'm going to have to jump in there, unfortunately. We did want to hear the answer, but we're starting to run out of time. Thank you very much for your presentation. It was really appreciated.

Mr. Vahe Kehyayan: Thank you.

PAUL CASOLA

ADRIANNE SEQUEIRA

The Chair (Mr. Kevin Daniel Flynn): Our last presenter of the day before we head off to Ottawa is Dr. Paul Casola.

Ms. Adrienne Sequeira: I'm afraid he's not here yet.

The Chair (Mr. Kevin Daniel Flynn): You must be Adrienne.

Ms. Adrienne Sequeira: I am.

The Chair (Mr. Kevin Daniel Flynn): You don't look like a Paul. Make yourself comfortable then, Adrienne, and we're all yours for the next 15 minutes.

Ms. Adrienne Sequeira: I think Dr. Casola must still be on the road. Oh, he's right here. Great. Good timing.

The Chair (Mr. Kevin Daniel Flynn): Okay, we're all yours.

Dr. Paul Casola: Thank you for having us. Actually, I was sitting in the other room, just waiting. I wasn't sure where my colleague was.

I hope that the committee got a copy of our presentation. It was a PowerPoint presentation that we'd submitted. We're going to work off those, given that we don't have AV abilities here.

I'll start by way of background. I'm a psychiatrist by training, but my practice has been solely in the area of addiction medicine. I was trained through the Addiction Research Foundation, which is now CAMH. I've worked in various facilities, including St. Michael's Hospital. I consult to regulatory bodies with respect to dual diagnosis or concurrent-disorder patients. My current practice includes work with individuals at the Salvation Army Harbour Light, to which I consult.

Adrianne Sequeira is a nurse who has worked since 1996 in the area of concurrent disorders. She and I hooked up around the year 2000, during the beginnings of what was at that time the substance abusing mentally ill program at St. Michael's Hospital. We have maintained a connection in terms of our professional pursuits since that time. Adrianne currently works at the Humber regional hospital.

What I'm going to do is let Adrianne present the first part of our message here, and I'll continue with the last segment.

Ms. Adrianne Sequeira: I wanted to start with the Auditor General's report, which was on a slide, which we don't have, obviously. It shows that 90% of the people evaluated by the province to need addiction treatment are not in fact getting it. This was released in December 2008.

Today there are two areas pertaining to concurrent-disorder services which we would wish to address: access to the substance abuse treatment system, and the organization of the treatment programs for the concurrent-disorders population within the treatment system.

The current means of self-directed treatment system access, or self-referral, other than by word of mouth, is via the DART and CONNEX databases—DART being the drug and alcohol registry of treatment—or an in-person telephone consultation with a member of DART personnel. From the patient and front-line clinician perspectives, this system is not effective in connecting—

The Chair (Mr. Kevin Daniel Flynn): Can I just jump in there? You're a little bit too close to the microphone. Apparently the mic is really sensitive. You don't have to get really close to it.

Ms. Adrianne Sequeira: Okay, sorry.

The Chair (Mr. Kevin Daniel Flynn): Everybody makes the same mistake.

Ms. Adrianne Sequeira: Thanks.

From the patient and front-line clinician perspectives, this system is not effective in connecting individuals with a concurrent disorder with the right treatment. The DART database, while comprehensive, is not user-friendly. Attempting to sort out which treatment resource best matches the needs of the patient is extremely difficult.

We did a search of the DART website for concurrent-disorders programs and got 70 hits. A data and information specialist from DART generated this list from the DART database: Ontario supposedly has 954 drug and/or alcohol treatment programs; 889 programs indicate that they will provide services to clients with mental health issues; 214 programs indicate that they offer services specific—restricted and/or specialized—to concurrent-disorder clients.

The DART database is supposed to generate a shortlist of possible treatment programs that may be suitable for the individual. An individual or clinician may also be able to shortlist treatment programs by telephoning a DART staff member. Once one narrows down one's options, the application process for entering a treatment program is onerous, involving a lengthy assessment tool package with 10 different assessment tools. This tool package, when initially introduced, was supposed to be a single tool to access all Ontario treatment facilities. However, this has not been monitored, and many treatment programs have added their own application forms to the package. Going through the package itself often takes two to two and a half hours. Most often, after going through this lengthy process, an applicant or the clinician acting on behalf of the patient is told that the patient is not eligible because of medications they are on, specific diagnoses or symptoms they might be exhibiting.

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There is inconsistency in the criteria, and front-line clinicians are often vague about their exclusion criteria. For example, individuals are told that the centre does not accept anyone on sleep medications, regardless of what these medications are. More recently, patients waiting for medical withdrawal management admission and attempting to line up post-discharge treatment are told they will have to be clean for three weeks before they can apply and be assessed. The treatment centre's rationale is that patients are likely to have seizures up to three weeks following detox.

Patients without skills to stay clean cannot be kept in an expensive hospital bed while waiting to be assessed for treatment, displaying a need for education of front-line addiction treatment centre staff about withdrawal management. The individual or clinician has wasted valuable time applying to a centre that has declined to assess the patient, and they have to go through the entire process again once the patient has relapsed. Better access to treatment would entail a database which provides upfront information on the exclusion and inclusion criteria for each centre to enable clinicians to be more efficient and effective at assisting their patients to find treatment. The current barriers to the system make it onerous, if not impossible, for an individual with a mental health disorder to match their needs with the appropriate service in a timely manner.

Another important factor in improving the current access would be to ensure that addiction programs that access funding to provide services to individuals with

complex problems, medical complications of withdrawal and/or psychiatric issues receive adequate education on these issues to provide good-quality care.

I'd like to hand over now to Dr. Casola.

Dr. Paul Casola: I want to briefly address the issue of the organization of treatment programs for concurrent disorders. I have a very simple model I want to describe, which is basically lifted and/or borrowed from the American Society of Addiction Medicine's protocols or patient placement criteria. I want to caution you that, as I've been told previously, for every complex problem there is usually a very simple solution, but that simple solution is usually wrong. However, I will say that there has to be a basis or a place from which we start, and we believe the simple solution that I am suggesting is a valid and reasonable way of starting to sort out the mess that we see in the addiction and mental health fields at the present time.

The suggestion we are making is that the treatment system in Ontario should be divided into three groups: addictions-only programs, concurrent-disorder capable programs, and concurrent-disorder enhanced programs. The definitions and the criteria for these specific programs are all listed with the American Society of Addiction Medicine's protocols. They're very much detailed, and I'm not going to elaborate on those at the present time.

In order to implement this rather simple concept, the suggestion would be that existing treatment facilities within the province of Ontario be delegated to provide these services. I don't know how you want to divide them up. You could divide them up by LHINs, you could divide them up by geographical areas, but the idea would be that certain existing treatment programs would be designated to provide the services based on the three levels which I just mentioned above. As I see it, there really is no need to reinvent the wheel here. There are existing treatment programs. Treatment for addictions as well as mental health for concurrent-disorder patients involves treating the substance use issue. It's a case of adding specific treatment modalities for individuals with concurrent disorders.

That's the essence of our presentation. Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you to you both. You've left a few minutes for some final questions for the day, starting with Christine or Sylvia.

Mrs. Christine Elliott: I just need time to consider this, but thank you.

The Chair (Mr. Kevin Daniel Flynn): That's fine. France?

M^{me} France Gélinas: No, no. Go ahead.

Ms. Sylvia Jones: My question falls with your, I guess, frustration—I don't want to put words in your mouth—as you try to find available treatments, as you go through this two-and-a-half-hour application process only to be blocked. Are you finding that there are beds available but they don't fit into the parameters of what you're looking for for your patients, or are there not

enough beds for the types of patients you're trying to serve?

Ms. Adrienne Sequeira: That's a tricky question, because when you look at the numbers of treatment programs that claim to be offering services for concurrent disorders, there seems to be no dearth of them. However, when you actually try to access those beds or those spaces, the treatment centre has a lot of exclusion criteria. They don't seem to be clear on what they will accept and won't accept, although on some things, like medications or certain symptoms, they are quite clear. But on other things, they wait until they get the application form before they decide whether they're going to accept this patient or not. It's very frustrating for the patient because, as we know, with addictions, there's a slight window of opportunity which, if you lose it, the patient goes out again for a period of time, and there are many more losses that go with each cycle of using.

In one of our slides here, it does mention that there's a dog's breakfast of services. That's basically, in essence, what we're saying. Someone needs to go in there and take a look at what's being offered and categorize it effectively so that those of us who are trying to access these beds know exactly where to go and it's provided for the patient in a timely way.

The Chair (Mr. Kevin Daniel Flynn): Thank you. France?

M^{me} France Gélinas: I have a whole bunch of issues. I'll put them all out, and you get to pick which one you want to answer. How's that?

The first one is, it's atypical that we usually try to link the clients, the patient, to the closest caregiver. In your field, clients often choose to go out of region. If we were to move through these three—you actually mentioned four in your paper, one being for specialized—would that mean we wouldn't need DART anymore, or would we still need it but under a user-friendly type of way? I'm thinking that for heart disease, you call it critical, and they let you know where there's a bed and then this is where you go. How come we don't have that in mental health and addictions? I don't know too much about your field, so maybe you can fill me in.

Ms. Adrienne Sequeira: I think with DART, way back in the 1990s, when setting the course happened, which was where they integrated all the addiction treatment programs in the province, the idea was that wherever there was a bed available, the patient would go. So it wasn't going to be regionalized. With the LHINs now, we're looking at catchment areas and that kind of thing, so a lot of times, some of the new monies are going towards programs which are regionalized based on the LHINs, and often people from outside the LHINs—certain treatment centres etc. or agencies that have developed relationships—are now having to turn people away because they're not in the catchment or whatever. However, DART was initially put in place so that every single treatment centre, supposedly, would phone in their availability, and the clinician who's trying to access the bed would just find out where the bed was available.

So in theory, it's a really good system. It's just that it's not user-friendly and it's just become a mishmash of services.

Dr. Paul Casola: Each region of Ontario, we believe, should have all three of these services available to them. We don't think people should be shipped from Kenora down to Toronto or wherever. We believe that within the region in which they live, treatment should be provided. The experiment of the 1990s of patients going to the USA for treatment was an abysmal failure and it should not be repeated. The idea is that there should be regional treatment with each of these types of services provided.

The DART provides a valuable clearing house or resource for patient placement. It's really a case of DART cleaning up its act so that the patients are clearer on whether they meet the criteria or not for any given program.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much. Unfortunately, that's the end of our time allotment today. Transportation leaves for the airport in about seven minutes.

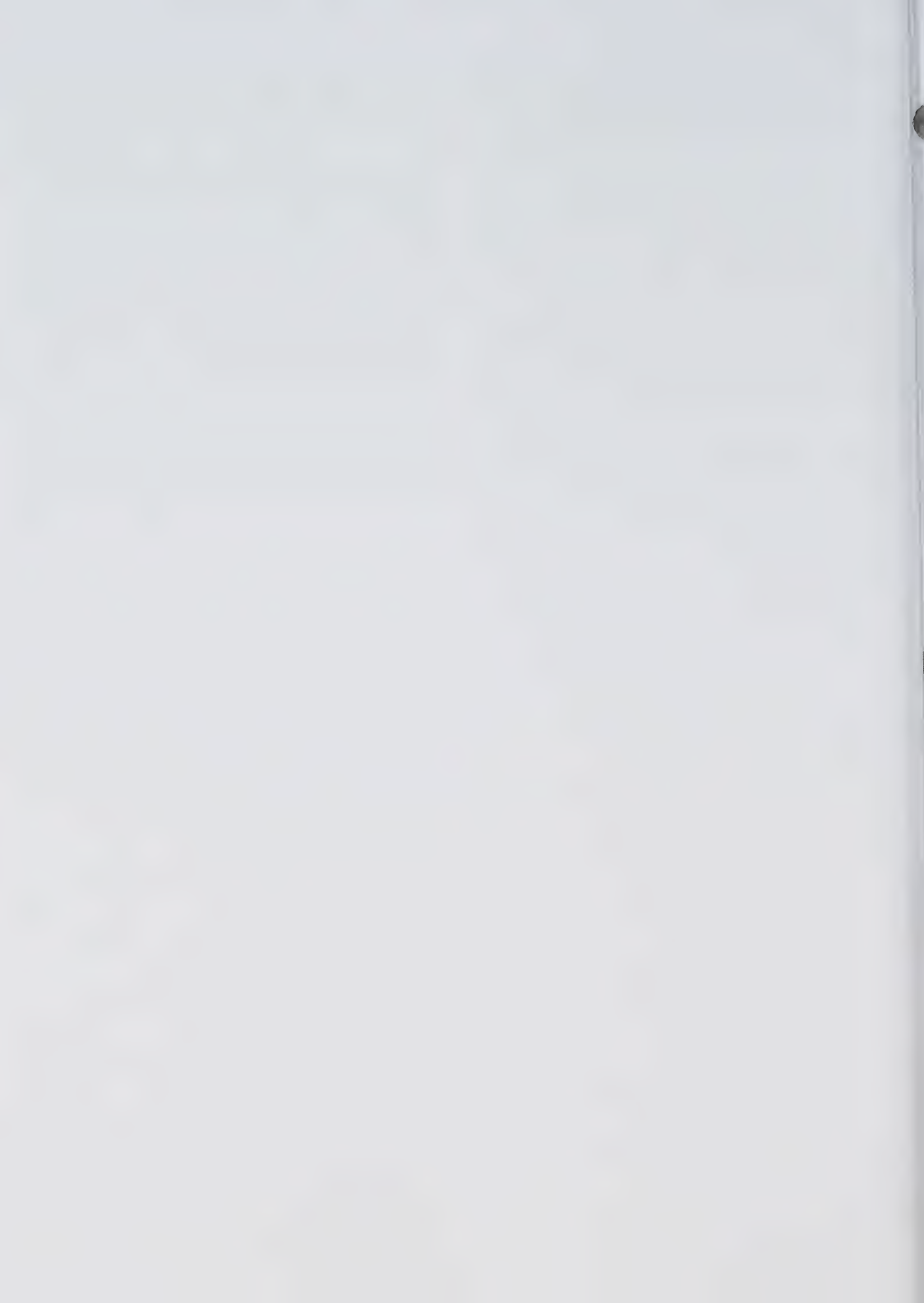
Mrs. Christine Elliott: Before we adjourn, Chair, can we just discuss a couple of issues about follow-up that I'd like to ask Ms. Hull to do?

The Chair (Mr. Kevin Daniel Flynn): Sure.

Mrs. Christine Elliott: Thank you very much. Today's presenters did great presentations, but I think there's certainly a theme that seems to have gone through—Lorenzo, you picked up on it in some of your questions—and that is, some of the issues to the involuntary treatment issue. I think it was Mr. Ross who mentioned that the Netherlands and Norway had some good experiences that perhaps we could take a look at and draw from to see how they're dealing with that particular issue. I'm wondering if you would be able to take a look at that, to provide us with information about how they're dealing with it, and then we can maybe have a further discussion about it.

The Chair (Mr. Kevin Daniel Flynn): Absolutely. Any other points? No? Okay, we're adjourned to Ottawa.

The committee adjourned at 1638.



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ISSN 1918-9613

Legislative Assembly of Ontario

First Session, 39th Parliament

Official Report of Debates (Hansard)

Wednesday 9 September 2009

Select Committee on Mental Health and Addictions

Mental Health
and Addictions Strategy

Assemblée législative de l'Ontario

Première session, 39^e législature

Journal des débats (Hansard)

Mercredi 9 septembre 2009

Comité spécial de la santé mentale et des dépendances

Stratégie sur la santé mentale et
les dépendances



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Telephone 416-325-7400; fax 416-325-7430
Published by the Legislative Assembly of Ontario



Service du Journal des débats et d'interprétation
Salle 500, aile ouest, Édifice du Parlement
111, rue Wellesley ouest, Queen's Park
Toronto ON M7A 1A2
Téléphone, 416-325-7400; télécopieur, 416-325-7430
Publié par l'Assemblée législative de l'Ontario

LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

SELECT COMMITTEE ON
MENTAL HEALTH AND ADDICTIONSCOMITÉ SPÉCIAL DE LA SANTÉ
MENTALE ET DES DÉPENDANCES

Wednesday 9 September 2009

Mercredi 9 septembre 2009

The committee met at 0917 in the Ottawa Marriott, Ottawa.

MENTAL HEALTH
AND ADDICTIONS STRATEGY
STRATÉGIE SUR LA SANTÉ MENTALE
ET LES DÉPENDANCES

SUCCESS BY 6 OTTAWA

The Chair (Mr. Kevin Daniel Flynn): Okay, let's get going, then. We don't have a gavel, but that was it.

Our first presenter this morning is Kelly Paolozzi. Come forward, Kelly. Make yourself at home. You're the first presenter this morning. Good morning. As we travel around the province, everybody's been getting 15 minutes so we can hear from as many people as possible. You can use that time any way you see fit. If you can leave a little bit of time at the end that might be better, so we can have a little brief discussion as to what you've talked about amongst the three parties. All that being said, the floor is all yours.

Ms. Kelly Paolozzi: Good morning. Thank you for giving me some of your time this morning. I know it's a very busy tour that you're on across Ontario. I'm representing Success By 6 here in Ottawa. Success By 6 is a collaborative community initiative. We are partners from the public, private and non-profit sectors committed to the success of all children in Ottawa. We represent education, police, the municipality, the province as well as business, so the multi-sector stakeholders that come to our table have a voice for all children and come together to champion and advocate so that we can have a better community for our children here in Ottawa.

We're working to help all children succeed for life by creating a community where everyone has the opportunity to reach their full potential. We've recently launched a framework for action that focuses on how we as multi-stakeholder champions can create change, which is based on the theory of change. We've focused on four key areas: creating public awareness, doing advocacy, focusing on the root causes of some of the factors that influence children, and we've based everything on the ecological model—so the child at the centre, the family having, obviously, a strong influence, and also the community and the society, based on policy.

We believe that families, communities, schools, neighbourhoods, as well as public policy decision-makers all have a role in helping children achieve their optimal development. We based all of this on a research project that we received funding for from HRSDC under Understanding the Early Years. We had done the EDI in 2005-06 on a sample of over 8,000 senior kindergarten children. In that sample, we received some interesting findings that helped us focus some of our attention on some key areas. One of them I want to highlight for this panel: the prosocial and social and emotional development—the prosocial and helping area. The children in Ottawa were not faring that well.

We know that in early childhood, the focus on mental health and addictions may seem kind of strange, at Success By 6, we thought that it was an important time for us to highlight that although our focus is early childhood—zero to six—it's still a critical time for early intervention and prevention, as well as the importance of pre-natal, maternal and parental focus on mental health and addictions. We know that a lot of the things that happen in a parent's life prior to birth—and we work with the Fetal Alcohol Spectrum Disorder Coalition in Ottawa as well as Healthy Babies, Healthy Children and public health—are key influences on how well the child is going to fare later in life. So we have started working with them on many things that have an influence. As well, we know that attachment is a key influence factor on how a child's social and emotional well-being is going to have an influence on their success later in life.

We've continued to reach out to the community to look at what the causes are, what's happening around social and emotional development, and we want to continue to do that work. But we wanted to present to this panel that it's critical that public awareness, a focus on early intervention, and focusing on the fact that there are many things that we can do before having to fund addiction programs and things like that that can happen early on in the prevention side of things—not to say that the intervention programs and school-age, youth and adult programs aren't necessary, but also that we strongly support the holistic approach that I think is critical in your document, the focusing on the family and that holistic approach to supports. Supporting an entire family is very critical.

The other piece that we wanted to highlight was that the collaborative approach you've represented in your discussion document is something that we strongly

support. Throughout our framework for action, we've advocated for an integrated and collaborative approach to service delivery in creating better access for families, that it is very critical that these are all community-driven and that you must work with community partners. Community partners need to get close to the clients. They need to have that voice at the table. We need to work with communities to find out how best to serve them in their local venue so that we can make sure that the services are accessible, culturally sensitive and appropriate for the families within those communities.

Our advice would be to ensure that within the local planning, you base your decisions on existing planning bodies, integrate with other provincial and federal planning that's already going on and build on the great work that's happening at the local level.

Around the awareness piece, we noted that you had a strong piece around public awareness and prevention. For us in early childhood, we note that as much as environmental risks are highlighted—and we know that mitigating risk factors in the environment within families are something that is always in the prevention, but they're often not highlighted when it comes to early childhood because there's a strong emphasis on building skills in early childhood that focus on numeracy and literacy. Often, those social and emotional skills are secondary to the preparation for school readiness, the focus on numeracy and literacy. An area that we would like to see highlighted in your work is obviously that social and emotional development is critical to mental health and prevention of addictions. Thanks.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today, Kelly. I'm sure there are some questions. Just so you're clear, probably what you're referring to is the report that was issued by the ministry.

Ms. Kelly Paolozzi: Yes.

The Chair (Mr. Kevin Daniel Flynn): The minister and his advisory group were a separate group.

Ms. Kelly Paolozzi: Okay, sorry.

The Chair (Mr. Kevin Daniel Flynn): But we're sort of travelling the same path.

Ms. Kelly Paolozzi: Okay.

The Chair (Mr. Kevin Daniel Flynn): I think we've just got a much shorter outlook on things, probably, at the end of our deliberations. The minister is putting together a 10-year plan with the advisory group. We're a committee of the Legislature from all parties. Our mandate is to report back to the Legislature by the spring of next year on a comprehensive strategy to address mental health and addictions.

Ms. Kelly Paolozzi: Sorry.

The Chair (Mr. Kevin Daniel Flynn): No, I just didn't want to take credit for the report because it's not ours, but I think we're on the same road or I think we're sort of going the same way.

Let's start off with some questions. Christine or Sylvia?

Ms. Sylvia Jones: Good morning. I wanted to touch on more of the early intervention and how to highlight that, if your group has put any thoughts together on testing or where that testing could occur—those types of things. You're not the first presenter who has talked about early intervention and capturing these kids before it becomes a crisis.

Ms. Kelly Paolozzi: Absolutely. We know that many of the programs that do exist, like Healthy Babies, Healthy Children and the home visiting programs—there are programs like Parents as Teachers that exist within the community but are underfunded. We know that reaching out to families within the home setting is the optimal way to be able to support them, but they are very resource-heavy, very time-intensive, and therefore require a lot of funding.

It's hard for reporting because you don't have high numbers, so a caseload has to be fairly small for the impact, but the impact is very great. It's difficult to represent it as showing a broad reach, although the impact is far greater. It's always that balance because you have to be investing quite heavily but the impact is much higher.

There are many examples of projects and programs but there also has to be a multi-pronged approach. We always struggle with how you reach out to the most vulnerable. Those are the programs that are the most costly and the most difficult to staff because of the intensity of the resources and the time commitment and the skill required to work with the families that are the most in need and the most vulnerable.

Ms. Sylvia Jones: Thank you.

The Chair (Mr. Kevin Daniel Flynn): France?

M^{me} France Gélinas: If you're thinking in the short term and thinking along the line of prevention in what you've been presenting this morning, would you support something that is accessible to all families and all children, or does your organization really focus on trying to identify children and families in need or at risk and focus your attention on them?

Ms. Kelly Paolozzi: An age-old question; I think there are advantages to both. I think having universal, accessible programs, you're going to catch families who are probably your less likely, the ones you wouldn't suspect as having issues. Some of the interesting findings that we found in our research are that there are always those outliers. There are the ones that aren't who you would expect.

We had neighbourhoods that, based on the socio-economics and the demographics of that neighbourhood, shouldn't be doing well. They shouldn't be ready for school. Those children shouldn't be faring well, but they actually are. The same goes the other way—socio-economically they are doing quite well. If you look at Ottawa as a whole, as a community, we're doing quite well. We're well educated, but on the school readiness scale, using the early development instrument, we're not far exceeding nationally against other communities. So it's hard to pinpoint or decide who is the most vulnerable. How do you decide that? That's where it gets tricky so you do catch those vulnerable people, because vulner-

ability is in some ways difficult to determine, but there are definitely times when targeted programs are required. When you think of very vulnerable neighbourhoods, when you think of teen parents, when you think of people who have histories that are clear—violence or addictions or cycles of poverty. So I think there has to be a balance. I don't think it's one or the other.

0930

M^{me} France Gélinas: Do I have time for one more?

The Chair (Mr. Kevin Daniel Flynn): Yes.

M^{me} France Gélinas: This is going to be an even tougher question. If you want to give up, you're allowed.

If you had to choose between the home visiting, post-partum, that takes place by the health unit or some of the early childhood programs where you work in groups, whether with targeted families or a universal program, which one would you qualify as the one we should invest our money in? We're talking good mental health.

Ms. Kelly Paolozzi: Do you mean—can you give me an example of the Early Years programs?

M^{me} France Gélinas: What I'm trying to say is: Should we invest very early, as soon as mom and baby go back home—have a visiting nurse going in and trying to teach good mental health and what skills the parents should have so that they look after the mental health of their babies—or should we focus more on programs once the parents start to go out with their children, once they're one or two or start to interact with one another? Is it better to invest very early, when they're infants, or invest when they're toddlers?

Ms. Kelly Paolozzi: I think there needs to be both, but I think the intensity of investment can be different. I'm a strong believer in building people's capacity, so I think that's the programs that you require. If you build a person's capacity early on, then their capacity to work and seek out opportunities to bond with other families and create opportunities for themselves is different if you've built that capacity early on.

The Chair (Mr. Kevin Daniel Flynn): Okay, thanks, Kelly. We'll move on. Helena?

Ms. Helena Jaczek: I'm wondering, when one of your stakeholders finds a behavioural issue that points to some underlying mental health condition, whether in your research you have followed up in terms of where the referral is made to? In other words, by category, is there a tendency to go—obviously it would be fairly individual, but would it be to the family doctor? Would it, obviously in some intense cases, be children's aid? Have you quantified where referrals are made to, and do you have any way of tracking outcomes of those early interventions, whatever they are?

Ms. Kelly Paolozzi: We've just started working on a pilot within our community with clinics that are integrated clinics: with Crossroads, which is our children's mental health unit in Ottawa; public health at the Ottawa Children's Treatment Centre; and our First Words, which is the speech and language and infant hearing program. They're doing screening clinics and assessments as a team across the community, and then doing referrals on

to each of their programs collectively. We had quite a high rate of referrals on to those programs.

In terms of referrals on to family docs, we don't have a strong connection to family physicians from our work as Success by 6. From the organizational perspective, I wouldn't be able to answer that.

The Chair (Mr. Kevin Daniel Flynn): Okay. Thank you very much for coming today.

Ms. Kelly Paolozzi: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Great presentation.

CANADIAN PAEDIATRIC SOCIETY

The Chair (Mr. Kevin Daniel Flynn): Our next presenter this morning is from the Canadian Paediatric Society. Marie Adèle Davis and Dr. Anne Gillies, if you'd like to come forward and make yourselves comfortable. I'll try to quiet the audience down.

Ms. Marie Adèle Davis: Thank you very much for inviting the Canadian Paediatric Society here to present to you today. I'm the executive director. Dr. Gillies is a community-based pediatrician here in Ottawa, so she is actually somebody who's out on the front lines and can probably give you really good vignettes as to what she sees and answer your questions.

I will just, as a start, simply quickly explain why pediatricians are interested in mental health. When we ask our members how much mental health they're seeing in their community practices, between 35% and 50% of their patients either come to see them because of a mental health issue, they've been referred by a family physician, or they've come for a stomach ache or a headache, but when they actually go through their diagnostic process, it actually turns out that the child has some type of anxiety or mental health issue. So they are dealing with a huge amount of mental health on a daily basis, and they're very important individuals in the continuum of care that we need to make sure our children, youth and their families receive.

I will very quickly go over what the CPS would like to see in a mental health and addictions plan for children and youth, and then I will pass it over to Dr. Gillies.

We very much agree with the previous presenter that there needs to be a focus on prevention and supporting families in providing a home that is, if you will, mentally healthy, the same way as we counsel families on how to keep their homes safe for children—now, of course, all we talk about is how they can try and keep them free of H1N1 and wash their hands—and also early identification of those children who may suffer from mental health challenges, because we know the earlier we intervene, the better the long-term outcome will be for that individual.

Once a mental health issue has been identified in a child or youth, we feel it is very important that they have timely access to the appropriate health care professional, be that a social worker, a psychiatrist, a psychologist, with no cost to the family. Cost, as I'm sure Dr. Gillies

can speak about, becomes a huge barrier for families without insurance to get access to timely care. We also know that when children don't get access to timely care, they fall further and further behind their peers in terms of their normal development. As pediatricians, we want to make sure that children stay on their normal developmental trajectory. Again, from a long-term prognosis point of view, we know that this is essential.

It's important that mental health care is delivered in a multidisciplinary team atmosphere. It's no one health professional who's going to be able to totally support a family. We feel that pediatricians have a very important role in that multidisciplinary team because of what they do for screening their patients for mental health issues, for the identification, for the treatment. Often, children with mental health issues or youth have comorbidities. If you think of young people with eating disorders, you also need to make sure that they're physical needs are being met. Also, pediatricians are important in providing ongoing care. In many cases, child psychiatrists will see a patient, they will identify and come up with a treatment regime, but much of the ongoing care is left to the community pediatricians in collaboration, and certainly that is part of Dr. Gillies's practice.

We also think consideration should be given for those children and youth who have some of the most severe mental health illnesses that they have access to a care coordinator who can help steer them through the system. In Ontario, there are a number of different ministries who have responsibility for different sectors of mental health care. For the family trying to navigate through that system, knowing which ministry to go to, what agency to go to, what community resources, such as Success By 6, are out there that can support their family can be very difficult.

My colleague was just sharing with me yesterday that the literacy statistics that came out for national literacy day were that the average Canadian has a grade 2 literacy level. One can imagine how difficult it is to navigate through government websites and everything else if that is your literacy level. So consideration should be given to identifying a care coordinator.

Lastly, before I turn it over to Dr. Gillies, given the size of the province of Ontario and the remoteness, especially for young aboriginal and Metis individuals, as well as Inuit, who live in Ontario, it's important that consideration be given to innovative ways of providing mental health services, be that through telemedicine, visiting health professionals, and that that care be given in a culturally appropriate way that makes it something that is welcoming for young people to seek out.

Now I will hand it over to Dr. Gillies.

0940

Dr. Anne Gillies: Thank you very much for the privilege of speaking to you this morning. I'd like to introduce myself briefly, because the scope of pediatric practice is vast, and people practise in varying ways across Ontario.

I'm what's called a generalist consulting pediatrician. I'm in private practice, and I see patients on referral from

family doctors about a range of issues, including biophysical health concerns, developmental concerns and mental health, behavioural and academic school concerns. I have a special interest in mental health. I've been in practice now for six years, and I work two days a week out of my private office and two days a week as a member of a multidisciplinary mental health team delivering outpatient mental health services at the Children's Hospital of Eastern Ontario. I've been there for three years. In that period, I've also participated in research related to collaborative care between pediatricians and other mental health clinicians. So this is an area very close to my heart.

In my private practice, over 50% of my patients are seen for the range of mental health, behavioural, school or developmental concerns that your committee is looking at. Addictions also surface regularly as part of the assessment process. In this part of my practice, I see patients ranging from two to 19 years of age, and I see them coming from a geographical area as far as a three-hour drive away. Pediatricians of every description are more plentiful in the Ottawa-Carleton area than they are almost anywhere outside this area in eastern Ontario. I see both Ontario and Quebec residents because I feel ethically obliged to do so, being a resident of west Quebec myself and knowing how scarce the resources are there.

The patients that I see in my practice I've divided artificially into those with biophysical issues and those with mental health issues, but, in fact, the two are often found in combination, and having a chronic physical or developmental concern places you at a higher risk, as a young person, of having comorbid mental health concerns.

I thought what I would do for you this morning is paint a human face on what we're seeing in clinical practice by telling you about three of my patients.

The first person I'd like to tell you about is a young woman called Jane—the names have been changed, obviously—who I first met when she was 13; she's now 17. Jane had a difficult beginning, growing up in a single-parent household where her mother's partner sexually abused her for several years, and this was not known to Jane's mother until she was in her mid-teens and manifesting many behavioural problems. She was involved with substance abuse, particularly alcohol, she did some drug experimentation, and because of family economic problems, found herself living in a shelter for a period of time with her mother. When it came out that she had witnessed violence against her mother by her father and had been sexually assaulted by her mother's subsequent partner, she was already in care for an eating disorder. She was diagnosed with depression while an inpatient in hospital, and returned to my care in the community, subsequent to her discharge from hospital. At that time—

The Chair (Mr. Kevin Daniel Flynn): Dr. Gillies, if I can jump in, the mikes get really sensitive when you get close to them. You can sit away from them and they pick

everything up, but they tend to pop when you get close to them.

Dr. Anne Gillies: Sorry about that.

The Chair (Mr. Kevin Daniel Flynn): No problem.

Dr. Anne Gillies: At the time that she was discharged from hospital, she had needs that encompassed housing, education, and financial support, as she was becoming an emancipated minor. As a result of that, there were multiple agencies involved in her care.

In my role as pediatrician, I found myself case managing for her contact with these agencies. She did have two social workers involved, but the coordination of her eating disorder follow-up, her support for post-traumatic stress disorder, her sequelae of sexual assault and her depression fell to me. Resources for substance abuse being thin on the ground, I also followed her for this issue. That sounds like a pretty complicated basket of issues, but this is not atypical for some of the young people who I see in my office, and it raises lots of issues about integration and collaboration between agencies, and, in a very real sense, how pediatrics and how medical services are funded when we're involved with the care of these patients. They're not structured to provide this type of comprehensive care or case coordination, and it may well be that the appropriate housing of this role resides outside of a medical practitioner's office, but I was one of the threads of continuity in her life, somebody she trusts and who was able to help her therapeutically in ways that she might not otherwise have accepted from yet another professional. So one of the points that Marie has made about case coordination and about the continuity of care that is required in order to be therapeutically effective with young people is something I'd like to underscore by the example of Jane.

I'll just tell you very briefly about the other two. The second one is a young woman who I met at age 18, when she was almost out of the pediatric age group. I was asked to see her by a mental health colleague because he was very concerned that she was not receiving any services because, with her severe anxiety disorder and agoraphobia, she had been housebound for a year. She had been receiving outpatient mental health services at a local mental health facility, and she was in fact going to high school there, but when her agoraphobia became more severe she seemed to be lost to follow-up. I was appalled at the idea that an 18-year-old could be housebound for a year without receiving care, and when I did go to meet her at her home, I learned that she was self-medicating with her father's prescriptions and was severely symptomatic. She was ultimately, within a few months, hospitalized, received appropriate care and is now receiving follow-up care in the community from a psychiatrist she was able to find for herself.

Both of these young women have remarkable strengths as individuals. I meant to tell you initially that Jane, the first patient, is a fiery, independent survivor, who, if she was speaking here today, would blow your socks off—an amazing young woman who's going to do very well. And Maddy, also a pseudonym, is a very

caring young woman who loves working with kids and is so magnetic that people bring their children to her house; she has become well known in her neighbourhood through word of mouth. I hate to describe these young people only in terms of their weaknesses, because they have significant strengths.

The last person I want to tell you about is a younger person, a boy, who I've known since age eight. Matthew is now age 13 and has multiple diagnoses: ADHD, anxiety, OCD; he's experienced significant bullying partly due to his short stature. His parents separated, and that caused him tremendous stress. He was diagnosed with adjustment disorder. He felt very stigmatized by his problems, by his family experience and by his short stature. This is a remarkably talented skateboarder who's a thoughtful, insightful, perceptive kid. After being treated for his ADHD in my office; after we identified bullying and it was addressed on several levels by parents, the school and in our office; after his parents had psycho-education around understanding what the meaning of the ADHD was, what roles anxiety and OCD were playing in his life; and after his parents provided very strong role models for him by showing openness and accepting of their own issues and seeking help for them as well as reassurance for him, he's doing very well.

Those three people are quite representative; they're not extreme. In my role as a community pediatrician, one of the things that has allowed me to provide perhaps more care than I would have been able to is the experience of working in a mental health setting where I have informal access to a lot of complementary expertise. So I'd like to make a plug for collaboration between pediatricians and other mental health clinicians as one of the ways forward, because, as pediatricians working in the community, whether we choose to or have a mental health bent or not, as Marie said, 30% to 50% of the kids who are showing up are presenting with these issues, and many people feel overwhelmed and not adequately resourced to deal with them under the current set-up.

Interruption.

The Chair (Mr. Kevin Daniel Flynn): That means your time's up. I didn't realize—it's like an egg timer. I'm just playing with it today.

Dr. Anne Gillies: I didn't mean to speak so long. Sorry.

0950

The Chair (Mr. Kevin Daniel Flynn): That was a great presentation. Thank you very much; very informative. Unfortunately, we don't have any time for questions, but I think you got your point across very clearly. Thank you for coming today.

SUE CLARK-WITTENBERG

The Chair (Mr. Kevin Daniel Flynn): Our next presenter this morning is Sue Clark-Wittenberg. Come on up. Make yourself comfortable.

Ms. Sue Clark-Wittenberg: Thank you very much.

The Chair (Mr. Kevin Daniel Flynn): Sue, if you'd introduce your colleague when you start—make yourself comfortable first—so we know who we've got.

Ms. Sue Clark-Wittenberg: I want to introduce my husband, Steven Wittenberg.

The Chair (Mr. Kevin Daniel Flynn): Pleased to meet you.

Mr. Steven Wittenberg: Good morning.

Ms. Sue Clark-Wittenberg: He's here for support.

The Chair (Mr. Kevin Daniel Flynn): Good. Like everybody else, Sue, you've got 15 minutes. You can use that any way you like. If you leave a little bit of time at the end for questions, that might work out well too.

Ms. Sue Clark-Wittenberg: I will do that. Thank you, sir.

Good morning, everybody. My name is Sue Clark-Wittenberg, of Ottawa. I am a former psychiatric survivor and now I'm an activist. I was psychiatrized for 18 years, from 1972 to 1990.

Bear with me; I had a mini-stroke a few years ago.

My first hospital admission was in the spring of 1972 at the Royal Ottawa Hospital. I was 17 years old. I was on the Whitney 4 ward. I weighed 125 pounds. I had never been locked up before. At my highest weight, I was 320 pounds. I gained 200 pounds; I've lost 90 to 100 pounds since.

I had gone to the emergency ward at the ROH because I run away from my upper-middle-class home in Ottawa because I was being emotionally and physically abused at home by my mother. In essence, I had a classic nervous breakdown, so to speak.

On the ward I was given lots of psychiatric medications which I had never been on before. On the medications I had many severe reactions—

Interruption.

Ms. Sue Clark-Wittenberg: That's bothering my ears.

Interjections.

Ms. Sue Clark-Wittenberg: It's hurting my ears, actually. Okay, I'll continue anyhow.

Mrs. Liz Sandals: Do you have any sort of electronic equipment in your—

Ms. Sue Clark-Wittenberg: We have cellphones that are off.

Mrs. Liz Sandals: It might be your cellphone—

Interjections.

Ms. Sue Clark-Wittenberg: They're both off. They're very sensitive, I assume.

It's gone now. I'll go over here. I'll continue. I hope you give me grace for that.

On the medications I had many severe reactions, like sweating, dizziness, dry mouth, agitation, slept 20 hours a day. I had an enormous appetite, slurred my words, had trouble with my coordination—I had to hang on to the walls—and I could not think clearly. I gained 30 pounds in the three months that I was on the ward. I was given a psychiatric diagnosis right away. I looked at my chart one night when the nurses weren't looking and saw on

my chart my psychiatrist had written I was a “schizophrenic”—

Interruption.

Ms. Sue Clark-Wittenberg: Oh, man, this is bothering me. I've got nerve damage in my ears.

Interjections.

Ms. Sue Clark-Wittenberg: Okay. Anyhow, I saw my chart when the nurses weren't looking one night and it said I was a schizophrenic and said that my parents denied abusing me. My brother was never contacted, who was 16 years old, a year younger than myself. Children's aid was never called, nor the police. Why? Because child abuse was a taboo subject in the early 1970s.

I was in and out of the ROH for the fall of 1972. In March 1973 I tried to hang myself in my room on the Whitney 4 ward and a nurse cut me down and saved my life. I'm very grateful to her.

I was getting more depressed at being locked up on the ward, so I was sent in the late part of March 1973 to the long-term-care facility in Brockville, Ontario, on ward H, a current ward, a locked ward. At BPH, I endured electroshock treatment, which damaged me, I got more pills and gained more weight. I had to endure public showers with my peers. We were not allowed to wear our clothes to the showers and there were no shower curtains while the female staff supervised. I got out of BPH in six months and went to a women's psychiatric group in Ottawa.

I had gone to these hospitals while I was psychiatrized for 18 years: the Royal Ottawa Hospital, Queensway Carleton Hospital and Montfort Hospital psych wards, and BPH. I received, from 1972 to 1990, 15 different psychiatric diagnoses and 14 different types of psychiatric medications. So I've been free of psychiatry, I've been off psychiatric meds since 1990, so I've been clean for 19 years. I've had no relapse. I've not been gone to a psychiatric ward since 1990. I've been free for 19 years. My last psychiatrist, who was at the Ottawa general hospital—it was in the outpatient department—told me I should never have been hospitalized nor given medication or shock treatments. I had suffered trauma from my childhood and I only needed a stable foster home for a year to get back on my feet. Dr. Bijoor told me that.

I am dismayed I was treated so badly by the psychiatric industry. I started to question psychiatry at length. In 1990, I dumped my psychiatrist, I dumped my psychiatric medications—it's not a good thing to dump your meds. People should be weaned off.

I've seen since then—from 1992 to 2007, for 17 years—many social workers. I saw a regression therapist, art therapist, occupational therapist, feminist therapist and battered women's groups. I've been married three times, and my two former husbands battered me. I went to the rape crisis centre for help, the sexual assault support centre, the Jewish community centre, the Catholic family service centre, the family service centre, the Wisdom of Women Centre, and Rideauwood for my psychiatric drug addiction. I am very grateful for the support of all of those groups and the individual

counsellors and therapists who helped me on my journey into recovery from psychiatry and psychiatric drugs. I have been off the meds for 19 years.

I do not validate psychiatry's use of psychiatric medications, electroshock, the use of psychiatric diagnosis and behaviour modification. Why? When I tried to get off the meds, I was brainwashed into thinking, "Suzanne, you're sick, you're mentally ill and you have to be on your meds for life." Well, I started to question that, and I did. I was often threatened—okay, at the Royal Ottawa Hospital: "Suzanne, if you go off your meds, we'll send you to Brockville. You want to go there again? You know what happened, you tried to kill yourself."

In 1988, I started to become an activist, and I started the Ottawa Advocates for Psychiatric Patients, a lobby group; Psychiatric Survivors of Ottawa; and the Canadian Advocates for Psychiatrized People. And my present job: My husband and I are directors of the International Campaign to Ban Electroshock, ICBE, in Ottawa.

Electroshock always causes brain damage, according to psychiatrists Peter R. Breggin and Harold Sackeim in the US. There is documentation to prove this, so I'm helping to lobby the Canadian government and all the provinces to ban electroshock.

There is no scientific proof nor data to prove that mental illness exists. Dr. Paula Caplan, a psychologist, wrote the famous book *They Say You're Crazy: How the World's Most Powerful Psychiatrists Decide Who's Normal*. Label jars, not people.

The Ontario government, I recommend, must do the following to ensure that people coming off their psychiatric medications have these services in place:

- facilities where a person can stay for a few weeks or months to get help;

- a 24-hour rehab program;

- counsellors who are psychiatric survivors, like myself, who have stayed off their meds for a long time;

- more affordable housing helping people when they come out of rehab;

- social assistance rates to be raised so people can have an adequate income to survive on;

- more 24-hour crisis lines in Ottawa. Once I called the Ottawa Distress Centre—and I'm not dissing them, because they're a very good service. I've used them countless times, but they do put you on hold. If someone's suicidal, that could be a problem.

- more programs like art therapy, massage, alternative therapies paid for by the Ontario government;

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- a crisis line run by psychiatric survivors who have been off psychiatric medications and who understand the issues and the withdrawal symptoms, like I had from mine.

When I got off my meds in 1990, I had no help and I had the DTs. I couldn't find a doctor to wean me off or a rehab, because they told me, "We can't help you here. This is for street drug addicts." I said, "I take psychiatric pills." He said, "Well, we cannot help you. Sorry."

- more family doctors trained in how to wean patients off psychiatric drugs properly;

- less prescribing of addictive psychiatric drugs like Lorazepam etc., with dangerous side effects;

- if someone is suicidal, the family doctor or psychiatrist should only prescribe minimal amounts of psychiatric medications;

- better training to 911 staff, ambulance and police regarding psychiatric patient issues;

- not labelling people with psychiatric diagnoses that do not exist;

- testing people for food allergies—I have a lot of food allergies;

- a national conference prepared by psychiatric survivors on recovery from psychiatric drugs, paid for by the Ontario government;

- employing more psychiatric survivors like myself with leadership skills to work with their peers. We have all been there; we understand all the issues. We are the experts.

I worked at the Royal Ottawa Hospital during the 1990s for many years. I was a speaker on psychiatric issues, so I was part of the consumer-as-expert program run by a peer, Marion Crow, and supervised by Mary Lou Weir of the Royal Ottawa education department.

I thank you for listening to me today.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Sue. You've left about six minutes for questions. Let's start with France.

M^{me} France Gélinas: Thank you for coming this morning. It's a pleasure to hear you.

You talk about the need for more affordable housing. I'll start with this: In your view, how would you see it working?

Ms. Sue Clark-Wittenberg: I know that we have a shortage in Ottawa, that there's a 10-year list and there's something like 15,000 people on it. I got my housing because in 1988, I was a battered woman in my second marriage and I got to the top of the list. However, there are thousands of people and families, many who have addictions, waiting for their housing. A lot of them spend their money on housing and they have less for food.

M^{me} France Gélinas: You also talk quite a bit about peer support. In your experience, which kind of peer support works best?

Ms. Sue Clark-Wittenberg: For me, it was peer-to-peer support. I would call some of my peers and say, "I'm having an issue with a marriage," or this and that and then they'd help me. We'd go for a coffee or a meal or just go to the park and talk, because my peers would understand. I was on medication. I was very lethargic. They asked me, "Well, what's going on in your life?" I found that the peer-to-peer support, for me and psychiatric survivors like myself, we understand—being on the ward, being off the ward, how to talk to a psychiatrist, group therapy. I was in every program except forensic and the children's program.

M^{me} France Gélinas: And how did you get access to peer support?

Ms. Sue Clark-Wittenberg: I called, and then I started my own groups. When I started my own psychiatric survivor groups, then we started to accumulate

people and then we started to talk. Then we had a group for psychiatric survivors; it was a rap session once a week. We had it at the Dalhousie Community Centre many years ago. It was called the Ottawa Advocates for Psychiatric Patients. I founded that and we had a rap session once a week. People could talk about anything from A to Z and it was confidential.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Sue. Are there any questions from the government side? Maria?

Mrs. Maria Van Bommel: Thank you. Your first suggestion or recommendation to us was a 24-hour psychiatric facility. Could you tell me a little bit about that? Is that an overnight? Who would be staffing it? How do you envision this?

Ms. Sue Clark-Wittenberg: Something like the Gerstein Centre. I did a leadership program there with Pat Capponi. I was impressed by the Gerstein Centre. Something similar like that needs to be in Ottawa and some major cities, because, in Ottawa, we don't have a Gerstein Centre where people can go to veg out for a few days and just try to regroup. We don't have that. The Gerstein Centre is very well run. I was very impressed. It was many years ago I went there to visit and do a leadership program.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Sue.

Ms. Sue Clark-Wittenberg: Thank you very much.

The Chair (Mr. Kevin Daniel Flynn): There may be some more questions here. Christine or Sylvia?

Mrs. Christine Elliott: I just had one question following along on the housing issue. Once people are able to be moved from some place like the Gerstein Centre, there are a number of community agencies that offer supportive housing at various levels. Are you in favour of that sort of idea, from a place that's maybe double-staffed 24/7 down to virtually independent living, with the goal of allowing people to be truly independent?

Ms. Sue Clark-Wittenberg: Yes. I think there have to be a lot of levels of housing for my peers—like you say, the group home, a Gerstein Centre or something like that in Ottawa; also, that they live with one or two roommates and then they become independent.

What happened to me—I went to the Marguerite House after Brockville; I was there. Then I lived with roommates on my own. I live independently now. But I found the support from my peers and the counsellors there, and the staff were very good to me. They helped me a lot to get back on my feet.

The Chair (Mr. Kevin Daniel Flynn): Thank you for coming today, Sue.

Ms. Sue Clark-Wittenberg: Have a good day. Thank you.

DARE TO DREAM PROGRAM

The Chair (Mr. Kevin Daniel Flynn): Our next presenter today is the Dare to Dream program, Erin Smith and Anie Belanger. If you'd like to come forward and make yourselves comfortable. There should still be

some clean glasses there for you for some water, if you need any.

Like everybody else, you get 15 minutes to present before the committee. You can use that any way you see fit. If you'd like to leave a little bit of time at the end for questions, that would be great as well.

Ms. Anie Belanger: Probably more time for questions than talking because I'm very curious; I'd like to answer questions.

The Chair (Mr. Kevin Daniel Flynn): No problem at all. The floor is all yours.

Ms. Erin Smith: Good morning, everyone. I'm Erin Smith, and I'm actually the youth engagement coordinator at the Provincial Centre of Excellence for Child and Youth Mental Health at CHEO. I'm here to support my colleague, mostly. Anie Belanger is the coordinator of the Dare to Dream program. She's here today to chat with you a bit about the program and its importance and also, more broadly, the importance of youth engagement in developing policy and in developing things like this strategy, and policy and system change in the province around child and youth mental health in particular.

So I'll hand it over to Anie.

Ms. Anie Belanger: I'm just going to start and explain to you guys briefly what the Dare to Dream program is. It's run through the Provincial Centre of Excellence—

Interjection.

Ms. Anie Belanger: I was trying to avoid that.

Interjection.

Ms. Anie Belanger: Okay, perfect. Thank you. The Dare to Dream program is a unique funding opportunity that is run throughout Ontario which provides up to \$5,000 to groups of youth who want to implement new programming or projects or ideas to either help promote mental health or decrease the stigma associated with mental illness.

We have two deadlines a year where youth can apply online, or however, to implement these projects. We have youth who will review them and take them from there and help the groups of youth start up their projects.

One of the most important aspects of the program is the fact that we do require all groups to have an adult mentor. That, we feel, is super-important in trying to make sure that youth engagement is happening, and properly.

My experience started not much unlike Sue's, except that I'd like to think that the mental health system—well, I can only speak to the child and youth mental health system, but I'd like to think that it has definitely improved. I'd like to actually attribute that to other strategies, maybe not a 10-year mental health strategy but other strategies, such as the implementation even of the Provincial Centre of Excellence, the Mental Health Commission of Canada, even; I do sit on the child and youth advisory committee for them. So all of that to say, I think that this strategy is the key to helping improve our system and making sure that people are able to seek out

the help they need and the help that they—I don't know what I was about to say.

Ms. Erin Smith: Youth engagement.

Ms. Anie Belanger: Youth engagement? What about youth engagement?

Ms. Erin Smith: Why is that so important?

Ms. Anie Belanger: Okay. As I was saying, the system has changed due to engagement of youth and consumers even at the policy-making levels, and I feel that not only is it important at a systems level, but also individually. The reason I believe that is because, when I was struggling with mental health myself, I was provided opportunities where I could make change and could help others who were in my situation.

1010

It started with a program called Youth Net. At first, I was doing programming there, but the way the programming was set up made it so that I was fully engaged; I had a say. I was able to make a sense of direction for the program. I enjoyed it so much that I did choose to do a co-op placement there, where I did start up different programming and was taken very seriously. My opinions mattered, and different things have come out of that, including my coordination, for example, of the Dare to Dream program.

I've been very fortunate to be able to have opportunities, such as this one, to speak to those who can make change, not only just here today but all over the province and, in some cases, all over Canada. I think that a lot of my recovery is due to these opportunities, being able to have a say and trying to make change. There's nothing more empowering, really, than to know that people value what I have to say and are actually doing things about it.

So that just goes back to, I guess, engagement, particularly of children and youth. I think it's 75% of cases of those who are diagnosed with a mental illness—their onset was before the age of 24. I believe that engagement of youth within the system, as well as this strategy in particular, is very key, not only to the development of the strategy but also to those individuals who are able to contribute, because, really, there is nothing better than feeling empowered and feeling like you have change, particularly with something as important as this 10-year strategy.

I have no idea where I'm at for time, but I think I'm running in circles with what I'm saying, so I'll let you guys ask questions.

The Chair (Mr. Kevin Daniel Flynn): No, you're not. You're doing a great job, and you've still got another nine minutes. But if you want to start answering questions, that may be the best way to go.

Ms. Anie Belanger: Yes, sure.

The Chair (Mr. Kevin Daniel Flynn): Let me start with one, and then we'll turn it over to the committee. My generation, when it was facing mental health issues, did it very quietly and almost with a sense of shame attached to it. You didn't talk about it with your friends. If there was somebody in your family who had a mental health issue, they were sort of hidden away. How do you

find it with your generation and your peers? Are you able to talk with your friends or with your family about issues like mental health?

Ms. Anie Belanger: I'd say that it has definitely come around. Is it absolutely there, where you can speak to it and you're not feeling stigmatized or whatever? No, and I think that's why this strategy needs to be implemented. But with programs such as Dare to Dream, with youth making their own projects and campaigns and whatever, I think that's definitely opening the doors.

You say your generation—because a lot of that generation still is around and parenting—

The Chair (Mr. Kevin Daniel Flynn): That's a good thing.

Ms. Anie Belanger: Yes, it is. It is. I'm trying to be really careful with my wording—really careful. But, no, based on the fact that that mentality still exists—though it is changing—there are parents with that mentality who are raising their children, perhaps with that same mentality; no, it's not completely gone. But are we getting there? I believe so.

The Chair (Mr. Kevin Daniel Flynn): That's good news.

Anybody from this side got a question? Liz?

Mrs. Liz Sandals: You talked about the Dare to Dream project and having youth being able to influence policy and their own outcomes. Can you give us some examples where your group would have been able to influence the policy at CHEO or influence what was happening to themselves? I'm trying to imagine the outcomes of what's happening here.

Ms. Anie Belanger: Sure. I should probably, then, clarify that when it comes to policy change and things like that, it's not so much the Dare to Dream program itself that is helping with that. There are other programs that are sort of partnered with Dare to Dream, for example, the New Mentality. That is a group of youth who are wanting to make change, to create a positive outlook in mental health—and encourage those to seek the help or however they want to do that.

There's one group in particular, either in Toronto or Hamilton, that had a scheduled meeting with the Minister of Children and Youth Services, actually, that fell through, unfortunately, I'm not sure on whose end, but they've created several different documents. For example, there's one document that was released as part of the new mentality, which is called Ready, Set, Engage!, which is pretty well a document or step-by-step guide to youth engagement, if you will.

So it's not so much the Dare to Dream program itself that I can speak to, but other opportunities that have been created through that provide that chance.

The Chair (Mr. Kevin Daniel Flynn): Any other questions there? Christine, Sylvia?

Ms. Sylvia Jones: Thank you for coming, Anie. Don't ever underestimate that you're the one who's making the change, not us.

I wanted to follow up a little bit on the funding program that you referenced at the beginning. I think it was \$5,000.

Ms. Anie Belanger: Up to, yes.

Ms. Sylvia Jones: Do you have to apply every year for that?

Ms. Anie Belanger: Every deadline, really. There are two deadlines a year. We don't tend to fund the same project twice. We try to encourage groups to seek other sources of funding after they've implemented their first project, but there are two deadlines.

Ms. Sylvia Jones: So have you seen those projects continue after that initial investment?

Ms. Anie Belanger: Yes, absolutely.

Ms. Sylvia Jones: And is there any consistency in terms of where they're getting funding after your initial set-up?

Ms. Anie Belanger: That's a very good question. I'm actually not sure where different groups have sought extra funding. I know there are also, for example, the United Way youth action grants which tend to do the same thing. It doesn't really need to address mental health, however.

Ms. Sylvia Jones: Trillium, probably.

Interjection.

Ms. Sylvia Jones: Trillium would be another angle.

Ms. Anie Belanger: Could very well be, yes.

Ms. Erin Smith: Community foundations as well.

Ms. Sylvia Jones: Community foundations? I'm not familiar with that.

Ms. Erin Smith: Some of the communities have tapped into—like the Community Foundation of Ottawa in the local regions, and then in other cases they've just found ways to sustain the programs in their schools. So they've seen the benefits during the first round and then they've just created the sustainability within the school budgets to have like a hangout room where people can go when they're stressed out or to do a campaign and a large assembly or that kind of thing.

Ms. Sylvia Jones: Are you finding most of the programs are based in the schools?

Ms. Anie Belanger: Yes and no. It depends on the time of year, which deadline it is. We tend to have a little bit more of the community—

The Chair (Mr. Kevin Daniel Flynn): Somebody's got their BlackBerry near the microphone.

Ms. Anie Belanger: Yes, there it goes. I just threw it away; sorry. So it depends on the time of year, I find, but no, a lot of people are tapping into places like Youth Net, for example, or just youth community centres, any place where they can find a reliable adult mentor who is familiar with their project and the mental health system or will be able to support them. It doesn't have to be a school.

Ms. Sylvia Jones: Thank you.

The Chair (Mr. Kevin Daniel Flynn): France.

M^{me} France Gélinas: France, est-ce que ta langue maternelle est le français?

Ms. Anie Belanger: No, but I speak it.

M^{me} France Gélinas: Est-ce que tu sais si un jeune francophone à Ottawa serait capable d'avoir les services

équivalents à ceux qu'un anglophone reçoit s'il a des problèmes de santé mentale?

M^{me} Anie Belanger: Moi, j'aimerais dire que oui parce que les programmes et les services que j'ai trouvés ont été bilingues.

M^{me} France Gélinas: Puis quand on parle d'une offre bilingue, c'est autant accessible pour les francophones que pour les anglophones?

M^{me} Anie Belanger: Oui.

M^{me} France Gélinas: Dans les demandes de subvention que vous recevez, est-ce que vous recevez des demandes de groupes francophones?

M^{me} Anie Belanger: Oui, absolument.

M^{me} France Gélinas: Que dirais-tu est la proportion, disons, si on regarde la dernière fois? Je ne sais pas combien de demandes vous avez eues la dernière fois.

M^{me} Anie Belanger: Pas beaucoup.

M^{me} France Gélinas: Pas beaucoup?

M^{me} Anie Belanger: Dix pour cent.

M^{me} France Gélinas: À peu près 10 % des demandes? Et ce sont de groupes bilingues ou de groupes francophones?

M^{me} Anie Belanger: Francophones; nous avons reçu un peu de demandes francophones et aussi bilingues.

M^{me} France Gélinas: Moi, je ne viens pas d'Ottawa; je viens du nord de l'Ontario. Parmi les agences qui existent, est-ce qu'il existe des agences francophones en santé mentale pour les enfants ou est-ce que ce sont toutes des agences bilingues qui offrent des services en français?

M^{me} Anie Belanger: Je n'ai aucune idée. Je m'excuse.

M^{me} France Gélinas: Ça va. C'est bien. Merci.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today. Great presentation.

Ms. Anie Belanger: Thank you for having me.

Ms. Erin Smith: Thanks for having us.

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RIDEAUWOOD ADDICTION AND FAMILY SERVICES

The Chair (Mr. Kevin Daniel Flynn): Our next presenter today is Paul Welsh from Rideauwood Addiction and Family Services. Paul, if you'd like to come forward. There are probably some clean glasses there, if you'd like some water.

Mr. Paul Welsh: You can see the dirt from here?

Laughter.

Mr. Paul Welsh: Bonjour à tout le monde. Good morning, ladies and gentlemen. I'd like to thank you for the respect and the compassion that I've seen so far in your ability to listen and ask questions. I'm glad, though, that I've got you early in the day. You have a pretty long list and I'll try not to lose you.

Can I just ask you a question? Because you have the written stuff in front of you, my plan was to kind of speak to it and follow along, but not read it identically. Is there actually going to be a transcript of what I say?

The Chair (Mr. Kevin Daniel Flynn): There will be a transcript in Hansard in both languages of what you say. We'll get everything you do by printed material and anything you say.

Mr. Paul Welsh: Great. Thanks.

I've worked in addiction for 25 years. I'm the executive director of an agency that has about 60 staff. We actually treat about 2,200 or 2,300 clients, but that 2,300 is pretty shy compared to the 4,500 who actually ask for our services. So that's who you see before you: somebody who's pretty excited about our results and somebody who's pretty grumpy about what's not being done. I'll try to curb my grumpiness so I don't lose you.

Ontario's addiction treatment system has seen 15 years of neglect, and there is no other way to describe it. That neglect, by the way, has included Conservative, Liberal, NDP, Conservative and Conservative governments. So I feel fairly free in saying it's not about one party missing the boat; it's about the political will missing the boat.

I noticed about 20 years ago that youth started to go on our waiting lists. These are youth who are pretty well daily drug users, alcohol, and they're in fairly serious difficulty. Now, adults go on waiting lists as well, but when you're talking to a parent and it's about their 14-year-old daughter, it really kind of gets your attention. Many of the youth who go on the waiting lists do not reappear in the system for treatment. Of these, something like 2,500 youth who come to us, about 35% are 15 or younger. Many of them will not show up in treatment, but they'll show up later in our drug treatment court or our homelessness addiction treatment programs, or the work we do with pregnant teens and young women with addictions with St. Mary's Home, or our referrals from youth probation, or the work that we do in the youth mental health court, or as adults on the Ontario Works addiction services initiative.

By then, the damage and the social and economic costs have really mounted. Some will have chronic illnesses such as hepatitis, AIDS, diabetes, unplanned pregnancies—that's not a chronic illness, but it's an issue. They'll drop out of school. They will be on Ontario Works or they will be incarcerated or in long-term care. We'll see them on television and in the newspaper headlines. This happens to us just about every year: A name and a face we know, whom we tried to get to or who came and didn't stay—we couldn't engage them because we didn't have enough hours in the week to see them—will show up dead or injured or something like that. That's our reality.

The addiction treatment system was frozen without cost-of-living for 14 years, and that just started to end about four years ago, albeit with modest adjustments. So the addiction treatment system has essentially lost 30% of its capacity as a result of that, and that hasn't been made up. We have lengthening delays, and services are increasingly late, increasingly thin and increasingly short.

Now, our agency kind of doubles in size about every 10 years. That's because we stopped going to the

Ministry of Health, which is our prime funder, for funding. We've gone everywhere we can, and we've been reasonably successful. However, we now have three provincial, three federal, and two municipal funders, and each one has its own accountability, each one has its own financial reporting system, and each one has its own planning table that I sit at. So the more successful I am in getting funding for our agency somewhere else, the more actually we all contribute to the dis-integration of a health-funded addiction treatment system.

Ontario has stumbled through three efforts to solve the problem by mergers, amalgamations, moving around organizations on a piece of paper. If you really take a look at a merger or amalgamation, you've got two organizations that are pressured in many ways to come together, and there could very well be a 25% increase in their salary and benefits plans. That exists in our system. So what's going to happen? Do you think the higher-salaried folks who may be unionized are going to say, "No, no, no. We should take a pay cut so that we don't lose treatment spaces"? So mergers and amalgamations very often reduce the capacity of the system, and that's a very important point to remember.

It seems to me, as somebody with consistent waiting lists of about three months over many years, that the solution may be simplistic, but why don't we start by just funding the need and the demand that's at the door of the system? That's a pretty decent indicator of a need.

Addiction has not received a lot of interest from the mental health system, with some real, notable exceptions in Ottawa, I might add, particularly CMHA, but now we're hearing more about addiction, and it's couched as concurrent disorders. So the funding seems to be going toward concurrent disorders often tied to housing in the mental health system, and the addiction treatment system is still not seeing major increases in funding.

Now, it's important to make the point here that mental health treatment is good for mental health; it does not substitute for addiction treatment. No amount of good addiction treatment is going to deal with a serious mental illness. As much as antibiotics are good and useful, they don't work on viruses. So that's an important distinction. What I'm putting forward here is a focus on addiction as a specific problem. There's lots of planning and lots of integration of services that can be done with the mental health system, and should be, but addiction and mental health are different problems and they require different treatments.

Addiction treatment works and it saves the economy millions. When you serve family members, you get better outcomes in treatment. You have children and husbands and wives who are at high risk for mental health and addiction and crime problems themselves, and the prevalence of those problems in that population drops if you can provide service in particular to parents of kids with addiction problems.

We have a drug treatment court program here. It's funded by the federal government. What we know is that our clients are essentially homeless and they have

chronic addiction and a long, long string of really stupid and annoying but non-violent crimes. They're in court many, many times a year. They consume about \$450 worth of drugs per day. They fund it through crime.

We did a survey with a whole year's worth of clients a while back and we asked them, "Previous to coming for six months, what was the value of the drugs that you used, and then in the six months that you've been here, what's the value of the drugs that you used?" The value of the drugs not used in one year was \$6 million. Now, that \$6 million was proceeds of crime. If you sell something on the street, you get about one tenth of its value, so perhaps the crime that went into that was \$60 million. The program costs about half a million dollars to run.

Our agency is fairly well known for its school-based addiction treatment. We're providing full-blown treatment programs in 38 high schools in Ottawa, and that is treatment; it is not prevention. It's two days a week per school. The kids are served in school during school hours, and they are referred by the school.

What we see are some fairly remarkable results. Grades go up. Kids who have been failing are passing. The achievement of credits goes up. The use of alcohol and drugs goes way down. About three quarters of those kids are flagged by the school as being high risk for dropout, and of that cohort, 80% complete the school year.

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Now, there's a study from the States that says for every kid who develops an addiction, drops out of school, turns to crime, the lifetime cost to the American taxpayer is \$1.5 million. Would it not be easier to put \$1,000 or \$2,000 into that kid in high school and actually turn them into a taxpayer rather than someone who is a draw? That's about the harshest economic analysis I can give you.

Addiction is common, it's treatable, and it's an expensive health problem if it's neglected. About 80% of people who are in prison are addicted. Prison costs \$80,000 to \$100,000 a year—okay, there are my stats from the States.

As far as the economy is concerned, according to the Canadian Centre on Substance Abuse, addiction costs the Canadian economy about 3% of its gross domestic product every year. Sixty per cent of those costs are to business because most people with addictions are not the folks on the market. Most people with addictions are employed, they're going to school, and they have distressed family members who are employed and going to school and having trouble at work.

Addiction affects 8% to 10% of Ontario's population, and the addiction treatment system receives 0.7% of Ontario's health budget. The Ontario auditor, in 1998 or 1989, said that for every dollar the taxpayer spends on addiction treatment, the taxpayer will save \$5.60. That's a pretty darn good return on investment.

Often at conferences and meetings—but I won't do it today—I ask people in the audience to close their eyes. I tell them I'm not going to embarrass them or ask them

anything uncomfortable, but I ask for the people in the room who have no family history of addiction to hold up their hand while everyone's eyes are closed. I won't do it with you, but I'd love to. What I find is that I've never seen more than 20% or 25% of the hands go up, which means that any group I've ever seen—and it's politicians, lawyers, federal employees, conferences all over the place—75% of the population does have a family member with addiction, and yet it gets 0.7% of Ontario's health budget.

The cost of a homeless person in Ottawa is about \$100,000. Now, you think about it: When you're living in a shelter, you get a cot or a mat and you get a meal, but you're out at 9 in the morning, unless you're really, really sick. So folks are on the street. They've got flu, they're getting worse, they're feeling lousy. They have all kinds of unaddressed health problems. They get into a fight, or a drug or an alcohol deal goes bad, or they're drunk and they stumble in front of a car. So what happens? A police car shows up, then maybe a fire truck with a defibrillator and then an ambulance. Then they're taken to hospital and they get their health care when they are swarmed with a team at emerg, the most expensive health care you can get. This happens many, many times a year. That's why it costs \$100,000.

Now, you can put a homeless person into a supervised apartment with addiction counselling coming to see them and you can do that for \$30,000 a year. It just seems so simple to me.

The Chair (Mr. Kevin Daniel Flynn): Paul, we have everything. You're doing a great job. You've got about two minutes left, so I'm just wondering: If there was stuff ahead of you that you really wanted to cover, you might want to look at it.

Mr. Paul Welsh: Good grief. Yes, I was afraid that would happen. So here are my recommendations to you.

First, how about a policy and a funding regime that says that within three years, we will meet the demand at the doors of the treatment system, and then see what happens? Most agencies across Ontario, and I meet with them regularly, have waiting lists of about four months.

You can fund that through a tax, a penny a drink, or you can fund that through some proceeds-of-crime legislation. There are policies on that that exist. There are precedents. One is the tobacco tax. The other one is how we fund gambling treatment: 2% of gambling revenues go to fund gambling treatment programs. So there are ways to do this that are not onerous.

I would recommend you maintain a distinct focus on addiction while you look to integrate addiction and mental health services in each other's shop. Addiction treatment services should be available in all primary health care, all secondary health care and all tertiary health care facilities. It should be available in schools, jails, prisons, all of that. That's what I mean when I'm talking about integration, true integration.

Then, how about asking the addiction treatment system itself to spend some time and come up with some recommendations? In my 25 years, I don't think that's been a serious request that's ever been made. Ask the

experts. We ask physicians what they need. We ask nurses what they need. Try that.

Develop a strategic plan for addiction. It doesn't mean that you need to put a firewall between addiction and mental health, but I'm saying, don't lose the focus on addiction, nor on mental health.

I'm going to stop there because I'm probably out of time, but I'm happy to answer questions.

The Chair (Mr. Kevin Daniel Flynn): You'll probably have to do that outside this venue, unfortunately, but that was a great presentation. You're one of the few people who have focused on addictions, from all of our presentations. So it was well received, I'm sure. Thank you very much for coming today.

Mr. Paul Welsh: If you're having a break and you do want me to hang around, I'm willing to do that, but if not, I'll go back to work.

The Chair (Mr. Kevin Daniel Flynn): Well, we don't get a break and you'll probably do more good in the community.

Mr. Paul Welsh: You should come work for us, then. Thanks, everybody.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Paul.

CANADIAN MENTAL HEALTH ASSOCIATION, OTTAWA BRANCH

The Chair (Mr. Kevin Daniel Flynn): Our next presenters today are from the Canadian Mental Health Association in Ottawa, Donna Pettey and Danny Lang. If you'd like to come forward and make yourselves comfortable. Like everybody else, you get 15 minutes for your presentation, and if you could save a little bit of time at the end, that might be helpful.

Ms. Donna Pettey: Thank you for the opportunity to be here today. We're very pleased to be here. My name is Donna Pettey, and I'm the director of operations at the Canadian Mental Health Association in Ottawa. This is my colleague Danny Lang, who's one of our community mental health and addiction workers. We were just figuring this out: Together, we have over 50 years of experience working in community mental health programs. Of course, most of that experience lies with Danny, clearly.

The Chair (Mr. Kevin Daniel Flynn): One of the old generation that's still around.

Ms. Donna Pettey: Yes.

We've provided a more detailed presentation to you in the package. Today, we're just going to hopefully do a bit of a Reader's Digest version, but also outline a case study that highlights what we mean when we say "an integrated treatment approach."

First of all, just a little background about CMHA Ottawa: We've been around here for over 50 years. We have a budget of over \$10 million, over 100 employees, and we're the grateful recipients of funding from the province of Ontario, the city of Ottawa, United Way and donations.

Who is it that we serve at our branch? Individuals with serious mental illness, as defined by the Ministry of Health, so we're looking at serious mental illness diagnoses, global disability and the likelihood of duration lasting for at least a year and certainly longer. Our clients are homeless or at imminent risk of becoming homeless, and we prioritize clients with multiple and complex needs. Last year, we served almost 1,000 clients, and 73% of our clients have a diagnosis of schizophrenia or bipolar disorder and about half of our clients, close to 500 clients, have a coexisting substance use disorder. Now, this is a very high prevalence point. Usually for a current prevalence point it's about 25% to 35%, but given where we engage our clients, it's not really surprising.

Our clients come from the emergency shelter sector, an inner-city health unit in particular, which is a unit within the shelters for individuals with complex medical needs; clients who are under the supervision of the Ontario Review Board within the forensic units; in the criminal justice system; in-patients, schedule 1 and schedule 2 facilities; and of course from families and self-referrals.

Now, for some of you, I'm sure, in a lot of your backgrounds you're familiar with the quadrant. The quadrant that we hang around in is: individuals with the high levels of psychiatric illness and the substance abuse to dependence.

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Specifically around concurrent disorders, a study that was done in the US—we don't have any comparable study here in Canada—found that less than 12% of those individuals who had a concurrent disorder were receiving treatment for both conditions. Now, almost 10 years ago we were faced with the reality that, on any given day, we have about 50% of clients with an SMI, a serious mental illness, and a substance use disorder, and as a mental health agency, we really didn't know what to do. There weren't many doors, wrong or otherwise, that were available to us, so we actually received some funding through the first federal SCPI grants and were able to spend some time in developing, first of all, a training program that last year in Dewars, where we trained about 200 clinicians in working with people with serious mental illness and co-occurring substance use disorder. But we also have a rather substantial group treatment integrated treatment program. Last year we served 150 of our clients in 18 weekly treatment groups that are ongoing treatment groups for this population.

This practice has been developed in best practice in the field, initially using primarily the Health Canada document, but also we had the privilege of working with Dr. Kim Mueser, who's one of the authors of the integrated treatment program book listed there as well and who is a consultant on the Health Canada document as well. Kim Mueser is one of the few researchers, psychiatrists, in the field who has developed specific group intervention strategies for working with this particularly marginalized population.

Quickly, then, what do we talk about when we talk about what are the ingredients of integrated treatment?

The Chair (Mr. Kevin Daniel Flynn): Donna, just before you go on, I should have mentioned something at the start; with the mics, you don't have to get right on them. I noticed you're trying to do this and trying to do the mic. You can stay a foot away from the mic and they'll still work perfectly.

Ms. Donna Pettey: Okay, thank you very much.

The Chair (Mr. Kevin Daniel Flynn): So you don't have to contort yourself.

Ms. Donna Pettey: So, integrated treatment: There are several components, and this is based on the Mueser model. First of all, we're looking at the integration of services, so we need to be able to provide treatment for both mental illness and substance use disorder simultaneously by the same clinician at the same time, ideally, within the same organization, but at the very least a coordinated treatment. The case study that Danny's going to talk about highlights how it is we're able to do that.

Comprehensive: We need to be able address all life domains. It's not just about addiction treatment, it's not just about symptoms of illness; it's about homelessness, it's about poverty, it's about work, it's about education, it's about family, and so we need to have that ability to look all the way around the individual and help them. We need to be assertive and going out to where people are. We wouldn't be engaging too many clients if we waited for them to come to us; we have to go and kind of hunt them down, which we're very good at.

It needs to be a long-term perspective—and I have a slide I'll show you at the end; we're talking about a substantial investment of time—motivational-based treatment based on the stages of change and stages of treatment, so that if people are at a persuasion change, they're not even thinking about their addiction problem—we need to have strategies for engagement for them to get them into treatment. And we need a lot of multiple, biopsychosocial interventions. We need to have nurses, social workers, addiction workers, housing, and that is what is really known as a comprehensive, integrated treatment approach.

Danny's going to talk, specifically, about what that looks like at CMHA Ottawa.

Mr. Danny Lang: This is an example of what integrated treatment would look like at CMHA, and if you have that handout that we had given you—kind of the disco ball one there; that one, exactly—in the middle, the case manager and the client work together to develop the plan. The case manager and the client hold that plan and they bring in the supports that are necessary. So it's not the client—how it has often worked is that the client goes from treatment to treatment to treatment, tells their story X number of times, and they carry the plan; whereas now there's somebody who helps them to manage that and brings in the supports to support them as needed. You can see what CMHA offers. We can do an integrated treatment model in-house, and we also really like to work with the community.

The case study that I'm going to give you is an example of three community partner agencies working together to help an individual through the stages of treatment: from starting in, an early persuasion, actively using, not really wanting to change, to sobriety.

I'll go on with the next slide. This is kind of a little bit of our motto: one client, one team, one plan. Really, the basis is we don't want that client bouncing around managing their own plan because it takes a lot of energy, and often they give up on it. We want to be there to help manage that.

The individual I'm going to talk about has been known to CMHA for about two and a half years. The partner agencies that were involved were the psychiatric hospital as well as a transitional group home with a recovery focus; those were the three partners that worked together. Initially, CMHA and the psychiatric forensic unit have developed a low-threshold concurrent-disorder group. We have an in-patient group that is for forensic clients with severe mental illness and concurrent substance use disorder. It's an in-patient group that's held weekly. That's where I met Rhonda; we'll call her Rhonda. I met Rhonda while she was attending this weekly concurrent-disorder group.

At the time that I met Rhonda, she had been in the hospital for two years. That's over 700 consecutive days of hospitalization. I'll give you a little bit of a rundown of the two and a half years that we've been with Rhonda and Rhonda has been working with our agency, and what it looked like.

Rhonda attends the weekly group, not really wanting to come at all, being forced by her doctor, and meets with the case manager. They're developing a rapport and starting to meet weekly. Rhonda is in group not really discussing a lot about what's going on, not really having any focus with her goals. Over time, the relationship starts to build, and all of a sudden Rhonda is talking about her substance use; she's talking about the length of stay she's been in hospital. All of a sudden she doesn't want to be in the hospital anymore. Rhonda's like, "I wanna get out of here. How do I get out of here? What do I do?" The hospital, the case manager and we were working together to support her. The plan is constantly changing, and we're adapting with it. Rhonda starts getting reintegrated into the community because she's been in the hospital for a long time. She's going out regularly with her case manager, integrating back into the community. Rhonda's four months clean now.

She gets an offer for a transitional group home where she's able to go in, have the opportunity to spend up to a year there with a recovery focus where she can do groups, continue working on life skills and stuff towards living on her own. She spends eight months in the group home. As she's transitioning in, there's this whole group, like a case conference, of people getting together, with Rhonda at the table, who's actively involved in her own plan and what's going to work and what's not going to work—and bringing in the necessary supports as needed and working in that integrated way. Rhonda moves into

the house; eight months later she's at a point now where she moves out. Through CMHA, where we have some rent supps, she's able to move into her own apartment for the first time in 13 years. She has sobriety now for over a year; she's working on almost a year and a half. She attends groups, attends her recovery groups, her focus stuff.

She transitioned from the hospital to the group home to her own apartment, all in an integrated fashion, with everybody working together, and not Rhonda running around talking to everybody and saying, "I did this," "I did this," and telling her story 50 times. Her energy is focused on getting better and on what she needs to do. When I talked to Rhonda about what really worked, that was one of the things she really appreciated, the fact that she didn't have to go out and do all the footwork all the time, that there were people there managing that. The resources were there, and she could focus her energies on what was needed, which was a full-time job, for really getting better.

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When Rhonda left hospital, she had been in the hospital for over 1,000 hospitalization days. So the first year of work with Rhonda was just around building a relationship and starting that process of change around her substance use. That's part of this process. Donna will talk about it. It just doesn't happen overnight; it takes sometimes a period of time.

I'm good, yes. Yes, I'll just run through this. This is one of the—

The Chair (Mr. Kevin Daniel Flynn): Just so you know, Danny, you have two minutes.

Mr. Danny Lang: Actually, I'll just pass it on to Donna. Thank you.

Ms. Donna Pettey: So the challenges are, as we move forward—pretty typical recommendations that we would have. We need a multi-faceted approach that addresses housing, that addresses issues of income, but really focusing on concurrent disorders.

Our last slide—nobody likes to see this—is the reality. On average, 60% of our clients in our concurrent-disorder groups have been in our group program for more than a year. So this is not a short-term, one-shot-deal type of investment, but at the end of the day, you can really solve problems for people as complex as Rhonda. This really does work.

Interjection.

Ms. Donna Pettey: Yes, it's within there.

The one last point is, we really endorse the notion of investing in community mental health and evaluation and research in looking at programs such as ours. It's very difficult to secure funding, so that's a really critical piece if we're really going to look at building an evidence-based practice and being able to make really good decisions with few dollars.

The Chair (Mr. Kevin Daniel Flynn): Thank you. That was a very good example of time management. You've got about 12 seconds left. Thank you very much for coming today. There was—

M^{me} France Gélinas: Can I use the 12 seconds?

The Chair (Mr. Kevin Daniel Flynn): Can you use the 12 seconds? You won't get the answer out in 12 seconds. I've been watching you.

M^{me} France Gélinas: What does "mixed French persuasion" mean? It's one of your 18 groups.

Ms. Donna Pettey: That's mixed men and women. Most of the groups are separate-gender-based but that's one group that is mixed. We're actually developing two more groups that will be gender-specific.

M^{me} France Gélinas: And I take it they're called "French persuasion" because they speak French.

Ms. Donna Pettey: Yes, it's a francophone group. "Persuasion" is the first level of engagement. It's persuasion, then active treatment and relapse prevention.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today; great presentation.

Ms. Donna Pettey: Thank you for your time.

M^{me} France Gélinas: Was I 12 seconds?

The Chair (Mr. Kevin Daniel Flynn): Way over 12 seconds. I knew you would be, though.

ONTARIO ASSOCIATION OF NON-PROFIT HOMES

AND SERVICES FOR SENIORS—REGION 7

The Chair (Mr. Kevin Daniel Flynn): Our next presenter today is from the Ontario Association of Non-Profit Homes and Services for Seniors, region 7. Come on forward, Josée Belke and Noreen Langdon. Make yourself at home. Like everybody else, you get 15 minutes. Use that any way you see fit. You can stay about a foot away from the microphones and they work perfectly.

Ms. Noreen Langdon: Okay, thank you very much. My name is Noreen Langdon. I'm the administrator of the Peter D. Clark long-term-care centre. It's a municipal home, one of the four in the city of Ottawa. My colleague Josée Belke is executive director and administrator of Residence Saint-Louis and Residence Élisabeth Bruyère.

We would like to thank you for this opportunity to present before the Select Committee on Mental Health and Addictions. We wear two hats today, Josée and I. We come as administrators responsible between us for 700 staff and for approximately—well, actually, 486 residents—no approximation there.

My home is a 168-bed long-term-care centre, plus a 48-bed dementia-care-bungalows centre for people at very high risk. Josée has two long-term-care centres, one which has a day program specializing in very high risk seniors who are waiting for long-term-care replacement, and she has that respite program two days a week. That got some extra money through the ministry to provide services for that program. My specialized unit—bungalows which were built in alliance with the Alzheimer Society of Ottawa-Carleton in those days—is funded through the same long-term-care dollars that ordinary long-term-care beds get.

We are here as administrators, we are representing 21 homes and we are administrators in the LHIN region 7 area.

Josée is going to present a case that most administrators of long-term care from across the province could give you if they were here today with us. It is an example of the day-to-day reality of all staff, residents, families and volunteers living in long-term-care homes in the province. So I'll turn you over to Josée, and then I'll come back with a few concluding sentences.

Ms. Josée Belke: I will tell you the story of Kevin. Yes, like many of you present, when we hear of a special case, we're quick to offer our solutions to everyone, and we do end up creating a band-aid solution, like for this gentleman, but at what cost?

So the case study is a 50-year-old gentleman, Kevin, who presents with depression and significant cognitive deficits. He has a wife and young children. He presents with episodes of aggression that were not listed on his admission paperwork when he came into long-term care. One night, he started uttering death threats to other residents, family members and staff. His physical aggression escalated to the point where, unfortunately, police had to be involved, and he was removed from his home.

He was assessed by psychiatry, admitted and experienced no further episodes of aggression while under their care. The reason for his behaviour was identified as a situational factor, most likely looking at the environment in which he's in—a long-term-care home—and he's only 50. The recommendation was to have a private room for him where he could be alone, have one-to-one staff supervision and take all the meals in his room. Now for me, being close to 50, taking all my meals in my room, I think of isolation. I think of, "Wow, now we're going to have to have staffing one on one with this gentleman, and where do we get the resources?"

The recommendation as well was that we should ensure that our staff know how to deal with these kinds of behaviours and that we should train them appropriately, so we readmitted him to the home, but we were fearful. A special volunteer was assigned for stimulation. We thought that maybe if we get extra resources like volunteers to spend time with him who are from the same culture, same language, this would help, but we had no success. We had special activities that were based on his needs and his current interests that were planned extensively with his family; again, with no success.

He used to go visit his home—just keep in mind that he's 50, so he has a house, a yard, a pool, neighbours and a neighbourhood—but the visits started decreasing because he started exhibiting sexual interest in his wife and behaviours that she hadn't seen in a long time. She was afraid for herself and she was afraid for her children.

More outbursts happened, and more extensive behavioural testing was done, looking at his activities of daily life—nothing observed, again, even when he was provoked in a specialized setting. Again, this must be due

to staff approach. That's what's going on in long-term care.

We explored the potential of transfers, looking at what's out there, and found that there wasn't much out there. On top of it, now there was a stigma attached with Kevin because he was aggressive. He transitioned back to our home, accompanied by behavioural staff that was to help us look at the behaviours and what we could do in-house. She soon realized that when he was admitted to our home, he actually got very aggressive and struck her. For the first time, they had seen the gentleman whom we were seeing under our care.

He was retransferred again. Unable to improve with his mobility, his activities of daily living, and now being incontinent, we needed a more integrated-systems approach, because he had nowhere to go and we were his home, so we took him back.

What I'd like to demonstrate today is, we took a look at these cases that happened in long-term care from a resident's perspective. Certainly the multiple transfers for treatment—the results were negligible, but the disruption to his world was significant.

He spends time in his room with little or no interaction, but he's not aggressive. Should that be our treatment or plan of care? He's 30 years younger than all of his roommates or people on that ward. Quality of life: I ask, what quality for a 50-year-old man? The stigma, his dignity is threatened, and his sense of being a member of his community is really eroded. He's devalued and misunderstood. He has lost his family, most of all.

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From the staff's perspective, the resident requires more care than we can reasonably accommodate. We try our best. We pool all our resources, but all those resources are pooled for one gentleman, while the other 169 don't have as much care as we'd like to offer. They're afraid of him, and I'm sure he can sense it.

We have high-intensity special funds that we receive from the ministry when we have a case like this, where we can access dollars for extra one-to-one, but it's for 72 hours. Seventy-two hours is long gone.

Staff continue to care and advocate for his needs, but they also feel devalued due to comments like "failure of not being able to fix this." This is not a success story for us; it's a sad story.

From the family's perspective, they barely visit. They've begun to be afraid of the behaviours and have admitted to being ashamed of the behaviours. They don't understand it and it's difficult for them. They're not sure how to explain it all to their friends, families and neighbours who ask.

People ask, "Is this a functional or a dysfunctional family?" I mean, does it really matter? They're going through and living through this. They've lost a dad and a husband, and he's lost a wife and his kids. They feel that they are to blame, that they're incapable of dealing with their loved one—sorry, I'm getting a little bit nervous—and the family has passed the burnout stage, which is

disheartening to us. The staff have become their family, at least an extension of this.

From a partners perspective, we've had other care areas that threaten not to take cases like this again from the home because they feel they have become a dumping ground, but we just don't have the resources or the care needs to be able to accommodate. I think there's a misunderstanding of our staffing levels and the structures in our homes.

We underestimate our advocacy for our residents and their families, because we do try to provide a holistic approach. So when we look at our opportunity today to present to this committee, we really want to reiterate our passion for our residents and the care that we do, but we have key elements that resurface during our discussions. This is not one typical case. These are cases that we discuss amongst ourselves with colleagues in long-term care. We need to look at the admission process and the documentation, the staffing resources, the training and entry to practice—why do people come to long-term care?—look at criminal checks.

Having support groups for these families: We do our best. They become part of our extended family, but we're not equipped to really be able to deal appropriately with them and all their needs.

We need to look at design for homes and have supportive legislation for this, and most of all, make sure that the homes that do accommodate these specialized units like we have are funded accordingly so we can feel we do a good and safe job.

Better integration of services and being at the table for solutions: We need to have respect amongst care providers in order to be able to look at the client in a holistic approach.

All of the key elements need to be incorporated in the mental health strategy in order to achieve a successful approach for the future and to enable us, in a safe manner, to look after the individuals who are an integral part of our society.

Quality of life is a way of living. It shouldn't be a luxury for anybody.

Ms. Noreen Langdon: Thank you, Josée.

Josée and I, as you can see, are not policy-makers. We're sort of action women. We have a lot of staff. When I talk about the almost 500 residents in long-term care, that means 500 families. I can't imagine, when I look around this room—with all due respect, there are mature faces like my own, and I'm sure that long-term care may have touched each one of you, particularly long-term care with family members who have dementia.

I've totally gone off my script. How much time do I have?

The Chair (Mr. Kevin Daniel Flynn): You've got almost four minutes.

Ms. Noreen Langdon: Oh, excellent. Okay. I'm better without a script. I wish we could script our day every day, but we can't.

Josée and I found a passion, and it's wonderful to find a passion for long-term care with somebody who's going

to remain in long-term care, probably while I'm getting it.

I'm very encouraged by what I see for staff coming into our business. But I would have to tell you that really Josée's case is a case, as I said earlier, where every one of us, and every one of the administrators in any area that you live in, can tell you a similar story.

I have specialized dementia care bungalows—fortunately, we were able to have an alliance with and great support from the Alzheimer Society of Ottawa. But I can't respond to the needs of the community in the way that the community expects, because I don't have the staffing dollars. It's not a specialized program. I have the same funding that Josée gets and that I get from my 168 beds in the long-term-care centre next door.

We do make a tremendous effort and we have taken on some very serious cases in the eight years that we've been open. Without an integrated system that talks to one another, you get burned really badly and people are at risk. I had a situation a couple of weeks ago where two lovely ladies in their 80s ended up in hospital. I refused to take that resident back, who went out to psychiatry. I'm considered in the community as a bit of a pariah because I did it before the 21 days of being out were up, because I didn't want that person back at 1 o'clock in the morning for my staff to deal with.

So long-term care needs to have specialized areas for people with mental health issues. Yes, there's overlying dementia when you get a little bit older, but the bottom-line aggressive resident needs housing and the proper care and the proper options to care. We have been trying to do it in long-term care for as long as I've been in it—I'm not going to tell you how long that is, but it's a while—and we are still struggling.

Our association, the Ontario Association of Non-Profit Homes and Services for Seniors, will be submitting, I think, one of the best submission papers that I have ever read. They'll be doing that sometime hopefully soon and probably in Toronto, because that's where the association is housed. Our recommendation to this committee is that it act on the recommendations that you will read from our association. I think they are succinct, they cover all the categories, and they cover everything that Josée has talked about in her example.

What Josée and I will do: Our next steps are to continue in the short term to, first of all, encourage colleagues to come into the business. That's what I will do. This is a systemic issue; it's not just a public sector issue. We're in the public sector, but it's a private sector issue. All long-term-care administrators would be singing the same song here today before you. A lot of us are getting closer to entering homes over the years, so we want to make them a better place and we want to attract young people to come into this business, and unless we make some changes, it is not going to happen. It's not a business of choice anymore. It's very difficult to find excellent staff, managers who are willing to manage 700 people. The young people out there who are applying for jobs don't follow the corporate line. I'm sure you've

noticed that. They have expectations of the corporations they work for to keep them safe. The ministry has many accountabilities—it's called safety. We're being accredited on Monday and it's all about resident safety. We can't do it and keep our residents safe. I'm hoping that we'll be listened to and that some specialized program and funding will come our way.

Thank you very much.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for your presentation: very well received.

Ms. Noreen Langdon: Thank you. We didn't have any mod cons, but we came. Thank you for listening to us.

ALZHEIMER SOCIETY OF OTTAWA AND RENFREW COUNTY

The Chair (Mr. Kevin Daniel Flynn): Our next presenter this morning is from the Alzheimer Society of Ottawa and Renfrew County: Kelly Robinson. Kelly, come forward. Make yourself comfortable. You've been here for a lot of the morning, so you know what the rules are. You have 15 minutes; use that any way you like. The mics work well if you're about a foot away from them. It's all yours.

Ms. Kelly Robinson: Hi. I'm grateful for the opportunity to talk with you today about the First Link program on behalf of the Alzheimer Society of Ottawa and Renfrew County.

When I was considering how I would open this presentation, I was thinking about the reality of the numbers, the prevalence of Alzheimer's disease and related dementias in our communities. We know that there are 2,500 new cases of Alzheimer's disease or a related dementia diagnosed in Ottawa and Renfrew county each year. We know that one in 11 people over the age of 65 in Canada will be diagnosed with Alzheimer's disease or a related dementia.

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I thought about these numbers and how likely it is that at least one of you would be directly affected by Alzheimer's disease or related dementia. I hesitated to mention these stats as I don't intend to frighten you. I realize the diagnosis of a dementia and all that is related can be incredibly scary to consider. That said, I decided before I went any further that I would ask you to think about someone you care deeply about, someone you will have the pleasure of knowing in their senior years, whether it's your mom, your dad, a sibling or your spouse. Today's presentation isn't about scaring you, it's about discussing the truth of the matter, how it affects us personally and how we can best respond. It's because the situation is so scary that we need to pay attention and respond accordingly.

What is First Link? The First Link program is a community support service developed in 2002. Its creation and implementation was a collaborative effort among the agencies within the Dementia Network of Ottawa, now the Champlain Dementia Network. Since then, the First

Link program has been piloted by nine Alzheimer Society chapters in Ontario. This pilot was completed this past spring of 2009, and now there are 25 chapters in Ontario rolling out First Link in their respective communities—communities such as Sudbury, Guelph, Toronto, Peterborough and so on.

The First Link program was developed as a response to the reality that persons affected by dementia typically only start to ask for support at a crisis point, at peak times of burnout or exhaustion. This is when people were reaching out, when they were their most emotionally and physically vulnerable. The intent of First Link is to prevent this, to at least minimize these points of crises as much as possible. The idea is to reach people early enough in the disease progression and connect these people to the various opportunities for support and information.

A diagnosis of dementia can be overwhelming. People need a starting point, a first step to what can be a very complicated system to navigate. We know that with in-time access to support and information, people are better equipped and knowledgeable about what's to come. With timely opportunities to discuss and plan, people are able to mobilize their support systems, develop the strategies they need to cope and tend to any unfinished business.

How does the First Link program work? At the time of diagnosis or identification of a dementia, a health care provider sends a First Link referral to the Alzheimer Society for us to initiate contact. We initiate the call, establish a relationship, determine the needs and make appropriate referrals. We connect people to the available opportunities for learning, services and support. We want people to feel invited to call us to strategize about a particular situation or simply for us to listen. We want people to know about the available services in the community and how they can connect with these supports.

Inherent in the structure of First Link are three key components: (1) outreach to promote early identification and early intervention; (2) to provide ongoing opportunities for in-time learning and support; and (3) community collaboration fostering best practice through a strong network of expert helpers throughout the continuum of care.

Outreach to promote early identification and access to early intervention: The outreach to primary care practitioners and community partners to promote the early detection of dementia are integral activities of the First Link program. Our regional experts tell us that in the average GP's office, 50% of existing cases of dementia go undiagnosed. That's a lot.

Outreach is essential to First Link. Regularly, we get calls from people like last week's Mr. M. Mr. M called into the office in a panicked state, feeling overwhelmed and frightened and unaware as to where he would turn. He described symptoms that sounded a lot like the presence of a dementia. However, when he described these same symptoms to his physician, they fell on deaf ears. Can you imagine how disempowering and demeaning it would be to be certain there's something wrong and to be told by a care provider you trust, simply, "Not to

worry. You're 80 years old. It's par for the course. What can I do about it?"

Our outreach message is one of support to primary care providers, that there are avenues available to access the tools and resources necessary to build their capacity to assess and treat dementia. First Link is here to help primary care with the related complexities that go with a dementia diagnosis. First Link can be a resource for primary care, to help lighten the load with what can be an onerous diagnosis.

Thanks to the direct referral process, we are able to move closer to our goal of early intervention and better able to establish a supportive relationship with our clients early on. Once we receive a First Link referral, we initiate that contact. At the time of the call, we simply ask how things are going, and based on the response of that call we find out what type of information or support is needed. Depending on the circumstances we'll refer, we'll connect people with opportunities for education, and again, we may just simply listen. Then the practice is to follow up on a regular basis, throughout the continuum of the disease—ongoing. The idea is that we establish a rapport early and maintain contact over time, that we create a meaningful relationship and stay in touch.

First Link has been deliberate in providing ongoing opportunities for in-time learning and support. Support and information need to be accessible and they need to be timely. Throughout the continuum of the disease, the Alzheimer Society support staff will check in periodically to make sure people are coping all right and are connected to the ideal resources. This in-time support, through follow-up, proves to be such a proactive and worthwhile practice. At the time of the initial First Link call, a person may report, "Everything's fine, we're just fine, no problem. Thanks for calling," but then at the time of a subsequent call, six months later, we'll hear a different response: "Oh, my gosh, perfect timing. It's awful. I don't know what to do. I didn't know who to ask for help."

In-time learning is also a key feature of the First Link program. We offer a five-stage progressive learning series, and each series is designed to build on one another. The sessions in the first series focus on what one might encounter in the early stages of the disease, and then subsequent series are offered in which the topics addressed are those that might present themselves further down the road, in the middle or later stages. These learning opportunities are provided repeatedly throughout the year so that there is a regular opportunity to access the required information, just in time, at any stage of the disease.

The third key component integral to the First Link program is that of community collaboration. We couldn't possibly serve the people the way we do without our community partners. We are very fortunate in the Champlain region to be so well connected with such great community partners and resources. The leaders representing the various organizations within the Champlain Dementia Network are actively involved in the First Link

program. First Link is an effective vehicle in the way of promoting best practice and enhancing quality care through strong connections among the experts in the field.

Based on my description so far, you may have the impression that First Link is such a success we have the situation well in hand. There are indeed challenges to speak of. I used to get frustrated by what sometimes seemed to be a very slow response to what felt like a very urgent situation. I developed a mantra for myself. "It takes a series of conversations," I would say to remind myself to be patient. It takes not one speech or presentation, but a series of conversations to effect change.

I learned quickly in this role that it takes a number of attempts to articulate to a family practitioner the benefits of adapting his or her practice to screen high-risk patients and refer to First Link. I realize it takes a number of repeated conversations with a caregiver in order for her to give herself permission to take a break and access the support of a respite program. I'm awake to the reality that it also takes a series of conversations with the powers that be, with government representatives like yourselves, to get the message across that we need to proactively prepare for the upcoming demands on our acute, community and long-term health care systems or we will face a devastating reality.

Currently in Ottawa and Renfrew county, there are 12,000 people with Alzheimer's disease and related dementias. In Ontario, by the end of 2009 there will be 180,000, and one in six of those people will be under the age of 65. We at First Link only reach a fraction of these people, in great part because of stigma. Just as I was hesitant earlier to scare you away with the statistics, similarly the majority in our community would rather pretend dementia is not a part of our reality. Fear is a reasonable response; however, this fear response perpetuates a taboo. We are afraid to talk about dementia. The absence of discussion means an absence of the necessary planning and adequate resources to support the cause.

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This is not rocket science; we've been aware of the upcoming increase in numbers of our seniors population since the baby boomers were born. We need sustainable resources to enable First Link to reach all those people who will need support. It would be incredibly short-sighted not to include the needs of seniors diagnosed with dementia in your discussions as you develop your systems and policies related.

Think back to the loved one you brought to mind when I first started talking. Can you be sure that person will not be diagnosed with a dementia? Are you confident that, if diagnosed, this person would have access to the necessary supports and quality care? Have you done everything you can to make the difference? Thanks.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Kelly. You've left a little bit of time, probably time for two questions. Anybody on that side? Liz.

Mrs. Liz Sandals: I'm assuming that your First Link program is mainly concerned, then, with education and with linkages to services. Is that the right assumption? You're not directly providing treatment?

Ms. Kelly Robinson: Yes, we are.

Mrs. Liz Sandals: Oh, you are directly providing treatment?

Ms. Kelly Robinson: We have a team of people in our program department of family support providers. They'll either provide voice-to-voice support over the phone, in-person counselling, or family meetings. If the situation warrants, then we'll refer to another organization. For example if there are extra psychiatric problems, if there is aggression or something, then we'll refer to geriatric psychiatry. But otherwise, we provide the support and the counselling, the learning, the support groups and in-office one to one.

The Chair (Mr. Kevin Daniel Flynn): Are you done, Liz, or do you have another one?

Mrs. Liz Sandals: I was going to say, then, in what percentage of the cases do you find that the disease is progressing to the state where you do need to refer on to psychiatric resources or institutionalization?

Ms. Kelly Robinson: I was afraid I'd get asked a percentage question. I don't know what per cent—

Mrs. Liz Sandals: Well, give me a sense; I don't need the exact per cent.

Ms. Kelly Robinson: Maybe in about a third of the cases we might consult with psychiatry or have someone get extra support from psychiatry, but for the most part, we can support people with the resources we have. All people will eventually need more support as the disease progresses.

The Chair (Mr. Kevin Daniel Flynn): Okay, thank you, Kelly. We're going to move on to Christine or Sylvia? No. France?

M^{me} France Gélinas: I'm just curious to see, where does your funding come from? For the other communities that are just starting up with their program, are they all funded through aging at home?

Ms. Kelly Robinson: Yes. For two of our positions, I believe, at the Alzheimer Society of Ottawa and Renfrew County, First Link funding is from the aging-at-home program, but otherwise, our Alzheimer Society chapter, 75% of our funds come from fundraised dollars.

M^{me} France Gélinas: From fundraising. So aging at home is not ongoing funding?

Ms. Kelly Robinson: Right.

M^{me} France Gélinas: So you have to have a strategy in place to continue to fundraise or hope that it becomes ongoing funding?

Ms. Kelly Robinson: Right.

M^{me} France Gélinas: And it's the same for all your colleagues? I think you said there were 25 of them opening up throughout Ontario.

Ms. Kelly Robinson: Right.

M^{me} France Gélinas: Are they all in the same boat where aging at home is only a part and they have to fundraise for the rest?

Ms. Kelly Robinson: Yes. That's why we're here.

M^{me} France Gélinas: Right. So stable funding, I guess, is at the top of your list?

Ms. Kelly Robinson: Yes.

The Chair (Mr. Kevin Daniel Flynn): Good. Thank you very much for coming today, Kelly.

Ms. Kelly Robinson: Thank you.

C.J. McCaffrey

The Chair (Mr. Kevin Daniel Flynn): If I can ask C.J. McCaffrey come forward. C.J., if you'd come up and make yourself comfortable. I notice you've been here for a lot of the morning too, so you know what the rules are. Just make yourself comfortable, and you've got 15 minutes like everybody else.

Ms. C.J. McCaffrey: Well, I'm very nervous, and I don't do well without a script, so I'm going to read.

My name is C.J. McCaffrey, and I was diagnosed with Alzheimer's disease in 2003, when I was just 58 years old. Are you aware that this disease can hide in your brain for about five to 10 years before it manifests symptoms? It takes about three years after that to be diagnosed and about three months to go through the testing. You have to do the math because I can't do that any longer. Suffice to say that I have had it for a very long time. No one person presents the same symptoms.

After crying in traffic at a red light because, suddenly, I did not know where I was going, I called my medical doctor and I asked her if I could be tested. My mother died of this disease, and I wanted to know how far down the road it was for me. At that time I was told there was a 18-month waiting period before I could get tested. Eighteen months is an extremely long time to get answers when early diagnosis is imperative to treatment of this disease—and I say "treatment" because there is no cure and there are no survivors.

I was referred to the Memory Disorder Clinic here in Ottawa, where they specialize in diagnosing early and complex cases of dementia. As I sat across from the doctor, frightened beyond belief, he gently told me, "It's not down the road; it is here, now." And he gave me medication right on the spot. Oh yes, and he told me that I had to quit working as a private duty nurse and go on disability pension. It was because I was in nursing that I did not have the 18-month waiting period.

Stunned, I went to the Alzheimer Society and learned about the First Link programs, which I attended enthusiastically. I was determined to fight this chapter of my life head-on, no matter what it brought. There, I learned about the workshops, the support groups and a lot about the disease itself. It was very empowering.

Then my journey stood still for about a year and a half as I slipped into denial and a dark depression. After all, I'm only 58 years old. As a single person, I was facing this alone with very little family support, and when people found out that I had this disease, they either rejected the possibilities completely or were too afraid to deal with it. I even had longstanding friends walk away

from me. You see, the problem is that I did not fit the profile of a person with dementia. I was not a little elderly lady in her 70s or 80s who lived on her own. My friends and family were more confused than I was.

After what seemed an eternity, I was able to reconnect with the Alzheimer Society and began fighting for myself. I was the youngest person at the groups, but I went. One of the biggest challenges that I had to face was to allow other people to help me find my new way. I was very grateful to the Alzheimer Society family for that. I learned that the sooner you are diagnosed, the better the chances are of having this medication work longer for you. When I woke up every morning wondering how much of myself I've lost today, I learned to listen to other peoples' stories. I am now in a support group where participants are all in the early stages of Alzheimer's disease or a related dementia, more in my age group, some even younger. We learn from each other's experiences, and I no longer feel alone. We help each other.

I was invited to participate in a blind drug study for a new medication and was then reintroduced to the special, caring and wonderful people at the Memory Disorder Clinic. I found out that they do much more than just diagnose Alzheimer's disease. They and the Alzheimer Society family gave me back my hope, and I began to look at each day as the first day of the rest of my life instead of with dread.

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There's a great need for more experts like them. The drug treatment that I am on now only helps my symptoms and will only work—I don't know how many more years. It does not stop the disease and it won't work for everyone.

One common thread for people having memory problems is that they're afraid to come forward and tell their doctors and families or even go for diagnosis. Doctors need to be better trained in this area to pick up on these things.

I'm watching a family member in this situation at the moment. She's been denying things, just like I did, so no one will find out that she is having problems. Maybe if it isn't Alzheimer's disease but another problem, then it can be treatable. If it is Alzheimer's and it's not talked about, then that person misses out on valuable treatment and support for themselves and their family. The Alzheimer Society can help in so many ways.

After diagnosis of Alzheimer's disease, you can lead a meaningful life. Some people, like me, who have been diagnosed early with this disease, want to speak out in hopes of helping others. I want to help fight the stigma that is still very much an issue.

We are told of the large increase in the senior population that's coming up in the next few years. What will happen to them? I believe doctors need better training to diagnose this disease. We need more doctors, period. You do not have to be in your 70s or 80s to get this. I'm living proof of that. The problem is now, not 10 years down the road. The longer that you're able to help people stay in their homes and live independent lives, the less it costs government in health care.

It has been very difficult for me, someone who is on their own, to accomplish that. I have no health benefits for medication, no spousal support, and every time that I went to the government for help, I got turned away because I was not in my 80s and I was not living on my own. We must look at this disease in a different way.

Yes, we need a strategy to help people learn more about brain health. We need a support system to help people with dementia and their families, regardless of what age they're diagnosed. Yes, we have an aging population. The time to act is now. We have a reason to care now. Our families and health system will feel the strain of more than 180,000 people in Ontario with dementia. Remember, this number of 180,000 is the number of people with dementia in Ontario right now. It does not even include the family members who must cope with its effects.

I thank you for letting me come and speak with you today. I feel that I have accomplished something every time I'm allowed to do this, and I hope that I've given you something to think about. If you have any questions, I'll try and do it without script, but good luck.

The Chair (Mr. Kevin Daniel Flynn): I'm sure you can. You've left about five minutes for questions, C.J. Thank you for your presentation. Let's start with Christine and Sylvia. You have questions, Christine?

Mrs. Christine Elliott: Thank you very much for coming today, Ms. McCaffrey, and telling your story. I think you've raised some really important issues with the comments you've made.

I have two questions. One is with respect to the home care aspects and any services or benefits that you're entitled to. Are you receiving help of any kind right now?

Ms. C.J. McCaffrey: When I reconnected with the Alzheimer's Society—actually it took me about two years to get a social worker, mostly because I fell into the depression. I did get Meals on Wheels for a while because I wasn't looking after myself—that kind of thing. But for the most part, the friends that I have and one connection with my family helped me stay—I'm able to look after myself in other ways.

My concern is, what's going to happen to me when I can't look after myself? Other people have spouses or money. Every time I went to the government, they said, "Well, we can't help you because you have a little bit of RRSPs, so you have to spend your RRSPs to pay for your medication." So all my RRSPs are gone, and now I'm living just on my disability pension. I never thought that I would want to be 65. I crave for when I go to 65, because now my medication will be paid for.

The Chair (Mr. Kevin Daniel Flynn): We have to move on, C.J., to the next question. Maybe you can keep covering it off. France?

M^{me} France Gélinas: You mentioned that, after you found out, you had a year and a half to two years of depression. Were you receiving care? Was it recognized that you had depression, and who helped you?

Ms. C.J. McCaffrey: Well, the lady that spoke before me about the First Link said that they did follow-up calls

and that kind of thing. At that time, I didn't get follow-up calls. I got the original referral, I went to the First Link programs, I saw all these older people and then I went home and I said, "I'm only 58. I'm not anywhere near them. I really don't have this." I slipped into denial, and then, even though I'm saying I don't, yes, it's there and you know it.

Other than going to my medical doctor, who I trusted for a long time—and she kept scratching her head. She said, "C.J., I don't think you do," but she kept treating the depression. So that's how I knew about the depression. I was treated for it, but it took me a long time to admit that I really, really needed help with the disease itself, and that's when I reconnected back with the Alzheimer's Society.

The Chair (Mr. Kevin Daniel Flynn): I think you have a little bit of support that came up there.

Ms. Kelly Robinson: I just wanted to add one comment, because that's exactly why we implemented the follow-up process. Initially, we trusted that once we made an initial call and reached out, and sent a package of information and provided the initial information, people would initiate their own calls and maintain contact—plus, we didn't have the resources. But we found out that we lost people quickly and easily, and that first call was nowhere near sufficient to support people, to empower them, to connect to what they needed. We needed to implement regular follow-up.

The Chair (Mr. Kevin Daniel Flynn): Thank you, C.J., and thank you again, Kelly. Unfortunately our time is up, but that was a wonderful presentation. You did great.

Ms. C.J. McCaffrey: Thank you.

Applause.

The Chair (Mr. Kevin Daniel Flynn): You're the only one that has got applause in all our hearings.

THE MEN'S PROJECT

The Chair (Mr. Kevin Daniel Flynn): Okay, our next presenter this morning is the Men's Project. Rick Goodwin, if you'd like to come forward and introduce perhaps who you're with. You've got 15 minutes like everybody else. You can use that any way you see fit. The mikes work when you're about a foot away from them. It's all yours.

Mr. Rick Goodwin: Okay, thank you very much.

My name is Rick Goodwin. I'm the executive director of the Men's Project. I'm sure you've been very patient through all these presentations. The only spin I would like to suggest is that I don't think you folks have heard a presentation from the perspective that we'll be offering today, given our status in being the only service provider in Ontario, funded by the Ministry of the Attorney General, to work with male victims, or survivors, as we refer to them, of sexual abuse. That will be our focus today, but before I start, I'd like to introduce Mark Feldstein. Mark Feldstein is my president. Like any non-profit, we have a board of directors—good-hearted

volunteers—and Mark's been a very impressive president, may I say. On with the presentation.

1140

We appreciate being invited to present to you folks. I think, before we start talking about sexual trauma and services for male victims, we need to speak a little bit about the agency. The Men's Project was formed about a dozen years ago out of perceived gap in community services here in Ottawa. The YMCA-YWCA were very important in establishing the agency to serve men around various needs, particularly those men who were sexually abused and sexually traumatized as children, but also to speak on other issues including men's violence in intimate relationships and issues of emotional integrity and fathering. Those are kind of our main sh-ticks, if you want to use that term. Since then, we've become—well, we still are the only service provider of our kind in Ontario, and one of four in Canada. So we're speaking to an area of service that's fairly new, fairly innovative and not well resourced.

What we're trying to do at the Men's Project is establish a kind of one-stop shopping for mental health services for men. We've been doing this with those areas of interest and working with the province around particular hot spots and particular critical issues concerning men, and that also involves the Cornwall inquiry. I'll be speaking to the Cornwall inquiry in a minute.

Of a few things that we do offer is a model of treatment for trauma survivors that has been recognized not only by the inquiry in funding a guidebook that has been published on that, but it has become the model of service in the state of California, of the lin6 organization down there. It's a model of service that's recognized as a best practice now in Europe through the refuge model or system association of service providers. So we think we're on to something because the notion of working with men and working around issues of sexual abuse is fairly new, not well thought through, and in so many ways we recognize that women, women survivors and the feminist movement have been about a generation ahead of what, as men, we're trying to do in terms of finding ways of healing and recovery.

When I talk about sexual abuse or sexual trauma, it is essentially a mental health issue. It falls under the justice system in many ways. What these men who attend our services need is counselling, mental health therapy, as you will.

Just a couple of more claims: In 2007, the Attorney General gave us his inaugural victim services award for service innovation. As well, the Aboriginal Healing Foundation sees us a promising healing practice for First Nations men. Part of the inquiry—we have official standing with the Cornwall inquiry. We're the only mental health agency with that standing, and as many of you know, we will be hearing from Commissioner Glaude as he reports on October 15. We're on the cusp of a three- or four-year effort to participate in gaining an understanding of what happened there.

In our presentation, we've included our contributions and our recommendations to the Cornwall inquiry. We

don't have time, certainly, to talk about that, but I want to underline the first one, which is, there's a need in Ontario to have services like ours for male survivors of sexual violence to find healing, recovery or treatment for that issue. It seems kind of a shame that in 2009, we're talking about this like it hasn't happened, but in fact, apart from Ottawa and Cornwall, there are no services funded by the Ministry of the Attorney General for male victims. This is an interesting issue because there are 39 centres in Ontario that serve women survivors. They're often referred to as sexual assault centres or rape crisis centres, and that funding has been delivered through the Attorney General's office for a number of years.

What we're pointing out here is that there is a gap in services that has stemmed from a policy—a very old policy, but one that is still with us—that says that victims' services, in terms of sexual violence, are only for women. So even though we know that sexual abuse happens to boys—we know one in six is the accepted figure of that form of violence—as men, there are not those resources because the funding mandates say that services are only for women victims.

We think by 2009—and we're hoping with the commissioner's recommendations with the inquiries—we'd like to see that changed so that victims of sexual violence in Ontario, whether they're women or men or children, all have access to needed services. If there is anything from this presentation today that will stay with you, it would be that piece. A victim is a victim is a victim, and no longer should we deny people services because of their gender.

We do believe that this lens of sexual abuse can add light to the connections between mental health and addictions, in speaking, of course, about men. In terms of actual numbers, that one in six figure adds up to close to a million males in Ontario who have been or will be sexually abused. If we combine that with the unknown figure of how many men are sexually assaulted as adults—we know that certainly occurs in our institutions and in other scenarios—we're talking about the needs of over a million Ontario men.

So what are the mental health presentations of these individuals? We know depression is the number one mental health issue for survivors. We know that suicide is a critical issue. Men commit suicide four times as much as women do. We know that, generally speaking, survivors are much more prone to suicide. Certainly, there are many studies of the higher rates of alcohol and drug use. Here we've quoted some studies showing two, four and 10 times higher addiction rates for those sexually abused as children. And we know with men there are particular mental health issues that we often don't even think of as mental health issues. But if you look at patterns of men's violence, patterns of men's risk-taking behaviour, of inappropriate expressions of anger, self-injury, all these can be attributed to early forms of childhood abuse. There is enough of a research base there that we are confident of these statements. Again, the Cornwall inquiry has funded us to provide that research to the Ontario government.

I'd like to go back to the fact that we've got in Ontario—and God bless them—39 centres for women, to work with women victims of sexual violence. It gives that notion that in every community there is a place for healing, and if we can attend to people's core injury—that's kind of the lingo in our business—we may not then need to spend as much attention on addictions issues because addictions issues will drop with those people who receive treatment. You won't find these individuals as much in our criminal justice system, because a victim who receives attention about their childhood trauma tends not to be in conflict with the law. Unfortunately, especially in Cornwall, we've seen that as a recurrent pattern.

I think, getting back to the notion of fairness and equality, we would like to underline the fact that all victims of violence should receive support, not only because it is the right thing to do, but it's also beneficial for our communities as a whole.

So that in essence is our presentation. If there are a few more minutes, we'd be happy to receive questions.

The Chair (Mr. Kevin Daniel Flynn): There are a few more minutes, Rick. That's great. There is probably time for a minute and a half for each party. We start with Christine and Sylvia.

Ms. Sylvia Jones: A quick question: You said the Men's Project began in 1997.

Mr. Rick Goodwin: Yes.

Ms. Sylvia Jones: But you don't have annualized funding?

Mr. Rick Goodwin: No.

Ms. Sylvia Jones: Is it considered a pilot project 12 years in?

Mr. Rick Goodwin: Project funding by its definition suggests funding of less than a year. However, for those 12 years, our funding has been renewed for project funding at March 31. One of our recommendations—I don't know if you saw it there—is that we would ask for permanent funding, given our record of service to the province. It would give us as an organization incredible security versus a question of whether we have funding next April 1.

1150

Ms. Sylvia Jones: So when you started in 1997, your mandate was specifically related to the Cornwall inquiry?

Mr. Rick Goodwin: No. When we started, it was community awareness in Ottawa of the gap in services with the Y sponsoring that initiative. It provided the original house at the Y.

Then the province invited us into Cornwall because Project Truth was starting up and no one knew what was going on with the male victims concerned with Project Truth. About 95% of the victims connected to Project Truth or the inquiry are male.

The Chair (Mr. Kevin Daniel Flynn): Okay, thank you, Rick. France?

M^{me} France Gélinas: I don't want to seem not supportive. I had never heard of your project and 15 minutes

ago I didn't know you existed, so take it as ignorance and nothing more.

There is a strong body of evidence that supports having female-only treatment. Do the same things exist to segregate men from general treatment? I'm thinking that in the community I'm from—I'm from Sudbury—we deal with a lot of survivors of residential schools. We deal with a lot of men who have dealt with the problems that you're talking about, but they receive their services through mental health agencies that target both men and women. The first question that came to my mind is, is there a body of evidence that shows that men do better if they receive their services from a gender-centric provider?

Mr. Rick Goodwin: That's a great term, "gender-centric." We do believe that therapy, as well as trauma therapy specifically, has to address one's gender, because the sexual violence inflicted upon these children is based on their core identity, which is being a girl or a boy, and trying to perceive why they were abused because they were a girl or a boy. I believe this is the basis for the network of women's centres which provide a feminist framework for their service offering.

I think our agency does it a little bit differently in the sense that half our staff are women. So it isn't the therapists, but it has to work in a way that speaks to men. We have to incorporate aspects of men's violence and understand it in their past abuse. We believe that that is a really important way for the trauma to be resolved.

The Chair (Mr. Kevin Daniel Flynn): Thank you. Jeff?

Mr. Jeff Leal: Just quickly as a follow-up to France's question: numbers or percentages that you have of male victims who came to you from the residential schools—do you have that number?

Mr. Rick Goodwin: I'm sorry—are you speaking about aboriginal men?

Mr. Jeff Leal: Yes, who were from the residential schools and were victims of sexual abuse.

Mr. Rick Goodwin: Yes, we do have them. I don't have numbers for them. They would be a minority, certainly, of our services.

Mr. Jeff Leal: Okay. Thanks.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming, Rick.

Mr. Rick Goodwin: Okay, thank you all.

JANE RUSSELL

The Chair (Mr. Kevin Daniel Flynn): Our final presenter of the morning is Jane Russell. Jane, if you'd like to come forward and make yourself comfortable. You know the routine probably as well as I do no, so I'll just turn it right over to you.

Ms. Jane Russell: Okay. My name is Jane Russell and I now live in Madoc. My son was diagnosed in 2000 in Peterborough with bipolar schizophrenic affective disorder.

Adam's illness reached psychosis in 1998, but as early as the age of five, he was having difficulty with noise and crowds. He suffered migraines for 12 years, which I treated with diet and environment as I was told that they were probably growing pains.

By 2000, he had been in and out of hospital countless times because of psychotic episodes. As a result of his being released while ill, I called the police to get him to hospital again. I was told to agitate him enough to strike me so they had reason to come. I did. The police arrived. They took Adam to jail.

Taken away in handcuffs, my son spent three months in the Brookside detention centre without his meds even though he had a diagnosis. His recovery was compromised and he suffers from fused discs as a result of being beaten by another inmate. Upon his release, he chose to self-medicate with methamphetamines and he became suicidal.

My question is, why was Adam allowed to make the decision to self-release, to voluntarily release himself when he was clearly not capable?

Skip ahead four years. Adam has accepted health and is able to go to the STEP program in Whitby. He arrives at Whitby hospital weighing 160 pounds—he's 6'1". That's not unusual. I visit every week for five months and notice he's gaining weight. I question doctors and nurses, and no one has an answer. Adam does: trips to the mall and freedom to use the hospital cafeteria at will. He doesn't have to exercise or attend the night activities.

When I pick him up for his release, he is 310 pounds and totting a certificate from the nutrition and wise diet classes that he attended at STEP. He is also on meds that are not working, and I am told by a leading psychiatrist that Belleville, which would be the service host since moving to Madoc, is void of any worthwhile mental health care. So now I'm faced with my son, and I will not have any help in Belleville and will have to deal with Adam's obesity and meds myself.

Four years later, Adam lives with my partner and me. He sleeps all day. I have to make all the meals so he won't overeat. He has two friends. He feels completely lost.

In January 2009, after working with him considerably on motivation and getting him up and doing things with him, as a group home is not an alternative, he has decided to move to Port Hope and has learned to invent activities to occupy himself. This is possible because Belleville does have a good mental health facility and we are pleased with his meds and his doctor, whom we still have. Adam has a worker, but I'm not sure where he is.

What he does now: In order to have a life and get ahead, he needs guidance. I still provide that. He has no professional to talk to or help him through the process of gaining any self-worth. I go to Port Hope twice a month. I help him cook, clean, exercise, find new activities in the town and try to motivate him to learn on his own. It works for a couple of days, and then the pattern continues.

I have not been able to take a full-time job, so I'm attempting self-employment. Adam might be able to find

a career if he had somewhere to go and somewhere to motivate himself. I have seen him work at the theatre with my brother, who is the manager of the Capitol theatre in Port Hope, and this kid never makes a mistake when he's asked to do a job. But the job ends in a couple of days, once the theatre performance is over.

What I am asking from mental health:

- Perpetual care. Gaps in treatment from diagnosis to independence affect results.

- Rethink voluntary release based on illness instead of age. The only important thing is wellness. What does age have to do with anything? We—family, parents—are trying to find reasonable care for the ill person. My son went to detention because of voluntary release.

- More involvement with family, as caregiver, regarding results, treatment and education.

- Periodic testing to assess ability and progress toward education or work possibilities. Right now that would be perfect for my son. What are his abilities? What has he been able to rise to since he's been on his own?

Gaps in the existing system: voluntary release comes up again. It creates a condition in itself and puts family in uncontrollable situations. There's no safe place for the ill person. Self-medicating with drugs and alcohol becomes so easy. Psychotic episodes can happen anywhere. Chances of staying on meds as prescribed are slim; chances of the right medication being prescribed in early diagnosis are unlikely. Ongoing monitoring of deterioration or recovery does not happen. Family members are affected in every way.

My final want is nutrition and exercise. Obesity is everywhere, but when it comes to treating mental illness, it obviously goes out the window. It must be a part of wellness. In my opinion, it has never been part of recovery, nor has alternative health care.

My asks:

- Create activity-driven programs for independent living that include skills development, artistic interests, and nutrition and exercise as part of a recovery program, and make it important to medical professionals.

- When a mentally ill person comes for help or is in crisis, allow enough time for that person to self-realize that they need help, not be told that they are ill, "These are the choices, now go away and let us know what you want us to do." That's more or less what happens when you're allowed self-release: "Here's three days, here's some meds. You can sign out any time you want. Bye."

- Create family network programs wherever there is a need or an interest, developed by consumers-survivors and caregivers.

1200

I've dedicated my life to Adam's wellness; I don't mind. However, there are many out there who can't do that. I receive phone calls in my area all the time, either anonymously or openly, from parents who don't know where to start. I'm not a psychiatrist but I've been able to help somewhat. But it's really bad in my area. I think, without having to put more money into any kind of help or programming, there's no reason why, as family networks or as these three things don't allow voluntary

release—that's ridiculous. And being able to create family networks so that we can talk among ourselves and find out what are the best avenues to go down first before running to hospital, running to the emergency—I've been there, I don't know, 20 times. It doesn't work. You need to be able to take the situation in hand, calm down, and direct that crisis to the right avenue and the right people. I think we can only do it through families and through open conversation. And, absolutely, we have to take nutrition into consideration. I know my son buys crap when I'm not there. Is Kraft dinner going to help this kid get better? I don't think so, but he doesn't know what to buy because he has no one who comes to his house once a week and says, "No, no, no. You don't do that." I do that, but should I be doing that? I don't know.

Anyway, there are the considerations, and Adam and I thank you for this time.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much. You've left quite some time for questions. I think our first person is France this time.

M^{me} France Gélinas: Thank you for your presentation. We, not this morning but through the different sessions we've had, have heard an awful lot about families finding that we haven't found the right balance between the right to freedom and liberty and the right to treatment. Most of the families or family members that come to talk to us or people with severe mental illness who come to talk to us approach this. Where would you see the right balance being struck as to the right of the person to make their own life choices, I will call it, the level of risk that they want to take, versus the family who have to pick up the pieces because the person is discharged too early and everything goes wrong? Where do you see that?

Ms. Jane Russell: I believe that in the early stages, when psychosis starts, as with Adam—he had an outburst and he was taken to hospital. It was clear that this child, at that time, was psychotic, that he was suffering from some sort of mental illness. I knew because of the things that had happened. So when he was taken to hospital by police, by family and by his teachers—the whole group of us were there—he was admitted and he was told openly, "Okay, you have three days to be under assessment. We're going to do this: We're going to put you in a straitjacket, we're going to put you in a lock-up room, we're going to try medication, we're going to sedate you, and three days later you have to make a choice." He is still thinking, "What happened to me?" So in three days, he doesn't know where he is and he decides, "I'm out of here. This is crazy. I could get better on the street by myself." Nine times we went through that exact same scenario.

So to answer your question, I believe that every person—especially youth—who is taken to a mental health facility because of a psychotic episode needs to be given the time to not only realize they've had a psychotic episode but the fact that they are going to need help and these are their options. Yes, they're going to be violent or perhaps they're going to be upset and they're going to say, "I have rights. I have rights." Well, you know what?

The world has rights too. To let that child out on the street, regardless of age—I don't care if they're 16 or 36; to let that person out on the street in a psychotic state like that because they have rights is not taking into consideration the rights of everyone else around them.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Jane.

Any questions from this side? Helena.

Ms. Helena Jaczek: Thank you very much for sharing your story. Obviously, you've had a great deal of negative contact all through the process with agencies and so on. Is there any example of a best practice that you could tell us about?

Ms. Jane Russell: Oh, yeah. I was really lucky. In Peterborough, after that horrible thing with the police and everything in Brookside, which was negative, Adam was then able to get to the schizophrenia clinic in Peterborough, where we had a really terrific experience, and God bless.

Ms. Helena Jaczek: What was the element that you found particularly good in that site?

Ms. Jane Russell: We had a worker who just never let us down. He was there whenever we needed him. He attended to Adam and Adam's needs and to every other client that he had. When he couldn't, he made sure that Adam was with someone else and that Adam knew that person equally and felt equally comfortable with them. The psychiatrists who were there were wonderful. They put Adam on the right path, absolutely. I had a fantastic experience, and it was the schizophrenia clinic in Peterborough.

Ms. Helena Jaczek: Having that one connection—we've heard the terms "case coordination" and "case management." I don't really like those terms, but that seems to be a really important aspect.

Ms. Jane Russell: It's very, very important, and that's what we're missing right now. That's what Adam and I are missing right now. I have had to invent everything I could possibly think of to motivate. I include him in my work. I say, "I need you for this drawing," or "I need you for that drawing," just to keep him motivated. What he's missing, we call it the Gord effect, because we don't have that. We tried in Belleville, but it didn't exist; it was just sort of, "Where do you want to go? Do you want to go to the mall?" We have amazing psychiatric support in Belleville, and I'm very thankful for that, but what he needs right now as a young man is to be with young men and get out there, to get up himself, and not go down the street and go, "Well, what do I do now?" He doesn't want to be with ill people. He doesn't need to be with ill people. He wants to be with well people. He needs someone to help him, to say, "You can do that." I've seen him work; I know he can work. He wants to work.

The Chair (Mr. Kevin Daniel Flynn): Thanks, Jane. Final question of the morning, Christine.

Mrs. Christine Elliott: Thank you very much, Ms. Russell. I think you've touched on really important points, and I want to reassure you that we are listening to parents, particularly with respect to the voluntary release issue. I think that's one of the most critical things we're

dealing with on this committee, so I really appreciate your comments and suggestions on that.

With respect to the whole issue of what to do and how to motivate people and so on, I think there is also a real need to educate employers more about the vocational opportunities that present themselves and that it's worth the investment to hire somebody who may have some or have had some mental health problems in the past. I think there's a whole community education process that has to be undertaken, and I think it's something that we should be looking at as well as part of this committee, because at the end of the day, everybody wants to feel that they have a meaningful life, that they're making a contribution, and I think that's an essential part of wellness as well. So I just wanted to let you know that we are thinking about all of those things, and thank you for being here.

Ms. Jane Russell: Well, thank you.

The Chair (Mr. Kevin Daniel Flynn): Maria, we have about 30 seconds left. I know you had a question.

Mrs. Maria Van Bommel: First of all, I want to say thank you very much for coming in. I know it's not always easy to talk about your own personal life. I had a sense of real frustration, an edge of frustration in your voice.

You mentioned a number of things that you would like to see happen. I was just wondering, if you had to pick one thing—I know all of them are important, but if you had to pick one thing that would give you some relief and would help your son Adam, what would it be?

Ms. Jane Russell: It would be having someone for him to go to so that he doesn't feel he's all by himself to make decisions. For me, it would be to create a network in a town where people who are facing situations such as mine have a chance to come and talk to people like myself who have been through it so that they can be directed to start the ball rolling. But more importantly, I want my son to have some support. He just needs a mentor.

The Chair (Mr. Kevin Daniel Flynn): That's a great way to end the morning, I think: Everybody gets one wish.

Ms. Jane Russell: That's my wish.

The Chair (Mr. Kevin Daniel Flynn): Thanks for coming this morning.

For the other members of the committee, lunch is in the Mackenzie Salon on the 27th floor, and for those of you who haven't checked out, checkout is at noon. More properly, I should say checkout was at noon.

The committee recessed from 1209 to 1305.

The Chair (Mr. Kevin Daniel Flynn): Okay, if we could all take our seats and perhaps get ready. Our staff's all set to go? Okay. We will call back to order again. We're a little bit ahead of ourselves, which is good. We'll try and keep it that way.

UNITED WAY/CENTRAIDE OTTAWA

The Chair (Mr. Kevin Daniel Flynn): Our first presenter this afternoon is the United Way—Peggy Austen and Dennis Jackson.

Interjection.

The Chair (Mr. Kevin Daniel Flynn): It's you, yes.

Interjection.

The Chair (Mr. Kevin Daniel Flynn): Okay. Well, we'd just like to start earlier, if it's possible.

Mr. Jeff Leal: What about Chief Daniels?

The Chair (Mr. Kevin Daniel Flynn): Chief Daniels isn't going to make it today, unfortunately.

At 1:45, OPSEU is presenting. They asked if they'd be allowed to take some pictures during the proceedings. I said that shouldn't be an issue, unless anybody didn't shave.

Interjection.

The Chair (Mr. Kevin Daniel Flynn): That's right. I'll just leave it at that.

If you were here this morning, you'd know that every group is getting 15 minutes, and you can use that any way you see fit. If there's any time left at the end, we'll just split that amongst the three parties and maybe have a discussion about what you've presented. Welcome, Peggy and Dennis. The floor is all yours.

Ms. Peggy Austen: Thank you.

Mr. Dennis Jackson: Thank you very much. Good afternoon. I hope you all had a great lunch in our great city. First of all, my name is Dennis Jackson. I am chair of the board of the United Way/Centraide Ottawa—le président du conseil d'administration de Centraide/United Way Ottawa.

In my other day job, I'm a vice-president with Scotiabank. I'm responsible for Ottawa and west Quebec. We sincerely appreciate the opportunity to be here to speak to you today. We sincerely thank you for your investment of your time, your energy and your resources in what we consider to be a very important subject.

The United Way/Centraide Ottawa's mission is to bring people and resources together to build a strong, healthy, safe community for all. In 2009, United Way/Centraide Ottawa made a record community investment of over \$17 million to support nearly 200 projects, programs and partnerships—and we emphasize "partnerships"—in more than 100 community organizations that promote individual and community safety, well-being, supports to unemployed and underemployed individuals, and programs that address crises due to poverty, unstable housing, violence and family difficulties. This amount does not include the substantial investment through additional leveraged opportunities with other key funders and partners.

The vast majority of these programs address mental health and/or addiction issues ranging from prevention to direct intervention in a number of populations, including children and youth, families, seniors, people with disabilities and new Canadians and immigrants. Our impact areas connect the lifespan of our community, beginning with Success By 6 through to aging at home.

Our vision for community impact is also about achieving meaningful long-term improvements to the quality of life of all Ottawa residents, addressing not just the symptoms of the problems, but also getting at the root

causes. It's also about making fundamental changes to social conditions and communities through research, public policy development, collaborations and partnerships.

Our Measures of Change document, which we've left with the committee—sufficient copies for everyone—is an example of how we are at the beginning to measure key performance indicators. We are quite proud of this research.

The United Way/Centraide Ottawa strategic partners in this work include all levels of government, donors, the health, social services and education sectors, business, labour, community leaders and other organizations, all wanting to make a positive impact on our community. Together, we target our community's most critical problems and challenges.

Unquestionably, addiction and mental health issues present significant challenges. We validate the belief that for too long people with mental illness and/or addictions have been stigmatized and marginalized. Creating healthy communities requires a shared vision and commitment from all segments of the community to work together.

1310

In the past few years, we have witnessed this harnessing of community energy in a number of initiatives to address mental health issues and addictions that we have been involved with—for example, Project STEP. Project STEP is our community's response to addressing the need for residential substance abuse treatment as well as education, prevention and early intervention for young people between the ages of 13 and 17. STEP stands for support, treatment, education and prevention. With the engagement of community partners, local champions and leaders, this campaign is raising funds to support the enhancement of a comprehensive substance abuse education and prevention program in our high schools, as well as to provide specialized treatment and counselling in a 24-hour residential setting in Ottawa. United Way/Centraide Ottawa manages Project STEP and is building on the work of the funders, donors, service providers and networks to leverage a community's ability to channel the resources to meet the needs of youth.

A commitment by the provincial government for the operating funds for the residential treatment centres and the school-based programming has to date leveraged over \$3 million in our community capital campaign. It is clear that community organizations, businesses and private donors are rising to the challenges of bringing both awareness and resources to address youth substance abuse issues.

The school-based substance abuse education and prevention program is a collaborative model involving schools and school boards, addiction agencies, teachers and student professionals, as well as students and parents. Other community partners include social services, Ottawa Police Service and Ottawa public health. Substance abuse counsellors partner with each school to support education and prevention initiatives and work with the

students and their parents who may require substance abuse intervention. The school-based substance abuse program has an unprecedented equal-funding partnership between our four school boards, municipal, provincial and federal partners, as well as Centraide/United Way Ottawa. Our shared vision has led us to begin to develop an agreed-upon evaluation framework.

On a personal note, STEP is something that we've been talking about for a number of years in Ottawa, but it has only been recently that United Way has stepped up to the table and has been aggressive with a number of other partners in saying, "It's time that we make it happen," and we sincerely appreciate the support of the province of Ontario, which is certainly going to go a long way to make this become a reality in the very near future. We know that because we're getting substantive commitment, both in leadership and in financial resources from the community, so we're very excited. "Excitement" is maybe not the word I should use, because it's something that's needed; it's crucial for our youth and our community, so I should maybe find a new word. You'll have to help me with a new word for "excitement."

Another example of our community coming together to address issues related to addictions and mental health can be found in the Leadership Table on Homelessness. In partnership with the city of Ottawa, the United Way is working with business leaders, government officials and community representatives to develop a comprehensive housing homelessness strategy with the goal to eliminate chronic homelessness in Ottawa. This strategy, called Destination: Home, involves adopting a housing-first plan, housing chronically homeless people and providing support and services, including mental health and addictions, that they need to remain housed.

I got the French one, right?

Ms. Peggy Austen: There's French and English.

Mr. Dennis Jackson: This is our most recent analysis of this project, Destination: Chez-soi.

In looking at the health and mental issues of our seniors, we have an aging-in-place strategy to support underserved, low-income seniors in their homes and to increase their independence and quality of life. United Way/Centraide Ottawa has provided both staff and financial support to the development and creation of the affordable supportive housing framework. This is another key initiative that has representatives from the city of Ottawa, business, the community and government leaders.

The aging-in-place model of supportive housing has leveraged provincial health funding and is currently in five Ottawa community housing seniors' buildings. This type of supportive housing can significantly reduce health care costs. For example, one elderly person had presented herself to the emergency department six times in a 10-day period, expressing depression, anxiety and feeling generally unwell. It turned out that there was no food in her apartment and that she was feeling very alone and isolated. Providing supports to vulnerable seniors where they live has demonstrated initial evidence of

significant decreases in the use of emergency services and in the diversion to long-term care.

With these examples in mind, we'd like to underscore our message today that the Ontario government must tailor strategies and services to meet the unique needs of the community and to stress that local planning not only on a needs basis, but with a strength-based lens, is critical to the success of the mental health and addictions long-term strategy.

The Ontario government's goal to mobilize a much broader range of support and services to address mental health and addictions will require engaging non-traditional partners and finding new and creative ways to work together.

We have found that the champions for these issues can be found both within government and, more importantly, within the communities themselves. Together, we need to amplify the voices of those who not only experience mental health issues and addictions themselves but of all those around them. Because of the nature of United Way's work with the community, we bring a wide variety of partners to the table, both traditional and non-traditional, to address mental health and addiction issues.

United Way/Centraide is in a unique position to support the efforts of the Ontario government. We are community-based, with partnerships across all sectors. We look holistically at the individual and do so across the lifespan. We combine the voices of many to develop true community responses that are not only reactive but are forward-thinking.

United Way/Centraide applauds an all-party governmental approach and offers its ongoing support in helping to achieve this vision in addressing addictions and mental health issues.

That concludes the summary of our presentation. I didn't check the clock, so I don't know if we have any time left.

The Chair (Mr. Kevin Daniel Flynn): You did. You left a lot of time. I think we'll probably get one question from each party. So let's start with either Sylvia or Christine.

Mrs. Christine Elliott: Thank you very much for coming today. Your presentation was really interesting and I really like the emphasis that you place on getting the community involved in the solutions. Maybe just using project STEP as an example, I was wondering if you could just go into a little bit more detail about how you engage the business community to get on board with this project and what you find works for you in that respect.

Mr. Dennis Jackson: I have the subject matter expert with me but I will start off by saying that we've had some people on the committee who have had their own children or grandchildren in some cases where we needed help and had to go as far as Minneapolis to get assistance. There just hasn't been enough care. So when we go to business people and say that we have opportunities to do things right here in our community, we can get them engaged fairly quickly.

The chief of police has been a big start—I won't say "a big start." We've had various people working for 20 years on this, saying that we need it. But the chief of police showed a keen interest. We were able to bring two other parties together who had shown a keen interest, including Janet Yale, who has been a very strong supporter—I'm sorry, not Janet. Janet is in the leadership on homelessness but she started working in STEP.

So to answer your question briefly, by us being able to show what resources we had, what we've heard that we need from mental health and addictions people on the ground, we've been able to bring together everybody. The province of Ontario really helped us by saying, "If you build it, we will come and help you run it." That really does help. That puts the sense of urgency in the community to raise the capital money we need to do it.

I'm not sure if I completely answered the question.

Ms. Peggy Austen: I think when it comes to the business community, it's also about finding the teachable moments and the language to be able to share the stories. There are a lot of misconceptions about addictions and mental health, and when we go out, it's identifying what the real issue is and how it affects our community. That's why we talked about being really relevant to different communities.

People don't know the extent of the problem and there's a helplessness about what they can do to help. So we're finding that in having our champions, which is really important because—for years I was part of the social service sector—we were beating on the doors and saying that we need to do this. But it's got to be a whole community voice and then everyone feels they have a unique and essential voice in that conversation. Some of our best advocates are those business people themselves now, and they're going out and doing the talks and talking about mental health as a community issue.

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The Chair (Mr. Kevin Daniel Flynn): We have about a minute left. France, can you be brief?

M^{me} France Gélinas: Can I be brief? I have lots of questions for you, but I'll pick just one. I see that you've adopted the Housing First strategy, which a lot of us have. We have in Sudbury. I don't know how long ago you went with it. Are you at a point where you can measure success?

Mr. Dennis Jackson: Do you want me to start with that?

Ms. Peggy Austen: Go ahead. Sure.

Mr. Dennis Jackson: We're coming to the end of our second full year; we're into our third year. We've created in this past year 80 new affordable residences for people on the street. I'm not sure what we did in the first year.

Ms. Peggy Austen: It was about half that.

Mr. Dennis Jackson: About half that. So we went from 40 to 80, so about 120. So we have started to measure it, but we've got a long ways to go.

M^{me} France Gélinas: Were you able to develop a range of housing options, as in 24/7 supervision to

transitional to supportive housing, "We call you when we need you"?

Ms. Peggy Austen: That's in the beginning stages. We've really just leapt off with, "Here's the plan and the action plan," but we are looking at all types of housing. The real importance is around the supportiveness and the things that will happen around them. We do have two youth shelters which have shelter beds, transition beds and then long-term housing.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much, Peggy. Thank you, Dennis, for coming today. Thank you for your answers, and thank you for your presentation.

Ms. Peggy Austen: Thank you very much.

M. Dennis Jackson: Quand tu passeras à Sudbury [inaudible] un bon nom français, Marcel Séguin—Marcel Jackson, je veux dire. Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thanks for coming today, Dennis.

CHAMPLAIN ADDICTION COORDINATING BODY

The Chair (Mr. Kevin Daniel Flynn): Our next presentation this afternoon is from the Champlain Addiction Coordinating Body: Deborah Hook, Lise Laframboise, Mike Beauchesne and Jonathan Moore, if you'd like to all come forward. Make yourselves comfortable. All groups are being given 15 minutes. You can use that any way you see fit. Hopefully, there's some time at the end for some discussion. The mikes work best when you're about a foot away from them—not that I'm trying to intimidate you or anything, but some people get very close to them. It's all yours.

Ms. Deborah Hook: Thank you. Good afternoon. Bonjour. I'd like to introduce my colleagues. Actually we were going to be four; we're three because we're hoping to have time for questions and be able to give you a spectrum of expertise. To my right, Mike Beauchesne is the executive director of the David Smith Youth Treatment Centre, an outpatient day facility for youth between 13 and 18. On my left is Lise Laframboise, who's the executive director of Pathways Alcohol and Drug Treatment Services of Renfrew county, an outpatient addiction treatment service. And I'm the director of the Ottawa Withdrawal Management Centre, a level 2 residential service for men and women 16 years of age and older.

The Champlain Addiction Coordinating Body is a community of practice, presently composed of 21 agencies, which has existed since 2002. As in many regions in Ontario, the addictions and mental health sectors are presently uniting to form a community of practice that will provide joint expertise and a common voice.

I'm going to carve out pieces to speak and the full presentation is here.

Ten per cent of the Ontario population lives in the extended Ottawa Valley region. It contains a dense urban centre, populous suburbs and remote rural areas, and

covers a large geographic area—almost 18,000 square kilometres. Close to 20% of the population is francophone, and there also exists a strong multicultural presence, with 14% of the population being members of a visible minority.

For our presentation today, we have focused on issues that affect the vulnerable population of persons with high addictions and comorbid mental health needs—concurrent disorders—who are presenting at addiction services.

According to a report presented by the ministry for 2008-09, there were just over 11,000 new referrals and just over 12,000 service discharges for the Champlain region. In 2008-09, there were over 18,000 service events that were delivered across the continuum of care throughout the 21 addiction agencies in the Champlain region.

Of those who have addiction problems and who are presenting at addiction services for help, there is a high prevalence of co-occurring mental health problems. For example, 77% of persons with alcohol-related problems have been found to have at least one psychiatric disorder.

With these complexities in mind, we will identify three key issues facing the Champlain region and suggest solutions that fall under the themes of “strengthening the workforce” and “system design” in the 10-year mental health and addictions strategy.

We have framed the issues and made recommendations using a client’s perspective as they seek treatment and move through the system and along the continuum of care.

At the outset, and even as we make recommendations for solutions, we must emphasize and remind you that while mental health and addictions have achieved enhanced public attention in recent years, overall funding for support in this area remains low in Canada relative to other OECD countries and low in Ontario relative to most other provinces.

First key priority: clients and their families. Accessing and then navigating through the many paths of the addictions and mental health system can be confusing and discouraging for clients and family members, particularly those with concurrent disorders. As a result, clients can often become lost in the shuffle between service providers. Moreover, clients and family members are not always fully aware of their treatment planning options and spend critical time on wait-lists while their condition deteriorates. Clients, along with family members who are trying to support their loved ones, are left with a sense of hopelessness as they struggle to obtain the services they want and need in a timely manner.

Although funding insufficiency rests at the core of problematic and untimely access to required services, we also believe concrete steps can be taken to help address issues related to access and navigation. More specifically, we are proposing an access model that directs newcomers to a central hub of coordinated service providers with structures and procedures for early identification, provision of supportive services and referral to a full service range.

Clients would receive motivational and entry-level supports through case management workers while awaiting access to treatment availability. At the entry level, case management support would also include linking clients to other required services such as primary care, income support programs, housing programs and other community support services. Treatment procedures would include a declaration to all clients of such partnerships and that the assessment/examination of their circumstances would address both mental health and addiction issues in their lives.

This coordinated access and navigational model would involve service providers across mental health and addictions interacting through trained case management workers. Clients would be connected with services in a coordinated treatment plan, without having to unnecessarily retell—and often retell—their stories.

Improving system design in this way will help to accomplish the noble objective of every door being the right door. With this coordinated access and navigational model, providers and programs work collaboratively to provide integrated and coordinated treatment options to meet consumer needs. Allied professionals can provide each other with navigational support that will ultimately lead to services that are appropriate for the client, proactive and ongoing.

Second key issue: geographic disparity in Champlain. There are important social, economic and geographic reasons why many people do not have access to addictions and mental health services in the Champlain area. As about half of the addictions service providers are located in central Ottawa, rural Champlain communities are often ill-equipped with necessary treatment services, and consumers face barriers of transportation and affordability.

We are suggesting that consumers in rural communities be better supported with an increase in personnel in the addictions sector in rural regions and by establishing transportation to and from addictions and mental health service centres.

We are also calling for an expansion of community withdrawal management services to allow consumers who are facing multiple barriers to access necessary support.

These improvements, in conjunction with coordinated access, will allow the addictions sector to develop system protocols to reach out to consumers, regardless of the geographic area. Also, stronger community support networks within the addictions sector will allow our service providers to create strong linkages with other sectors that will benefit consumers facing the most complex of needs.

Increasing the number of professionals and improving the rural/urban system flexibility will contribute to a more seamless system that is able to deliver comprehensive treatment to clients across our region.

Third key priority: the workforce. The addictions sector is experiencing serious staff recruitment and retention problems. In our region, qualified addiction treatment personnel are frequently lost to larger health institutions—hospitals—as well as to other sectors—

education and even mental health. Addiction agencies are not able to offer competitive salaries and benefits packages to attract or retain personnel and must often offer contract positions to save costs. As such, qualified professionals who have gained valuable experience in addictions often gravitate to other, better-paying, more secure positions elsewhere, outside the sector. This human resource instability is detrimental to the clients we serve and poses unnecessary hurdles in an already-challenging work environment.

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In addition, our education system does not adequately train and equip the emerging workforce to work with the complex needs of clients with concurrent disorders. While the majority of clients entering the addictions and mental health system have concurrent disorders, the majority of counsellors are under- or ill-equipped to provide fully appropriate support and services.

Lastly, continuing education in the addictions sector is often more about what particular agencies can afford rather than what is needed—obviously an inadequate reality, given the complex and ever-changing needs of the clients we serve.

We recommend establishing wage parity between professionals in addictions, then in mental health, and then with other related health sectors.

The education sector must work with practitioners to ensure that the emerging workforce is fully and adequately equipped to provide specialized services to clients with concurrent disorders.

Personnel already within the workforce must be required—but also supported—to attain the appropriate competencies to work with clients with concurrent disorders and update their skill set as needed.

Finally, associations within the addictions and mental health system must be given the means to further develop a standardized clinical certification procedure and capacity to enable workers to be certified and maintain up-to-date clinical qualifications.

In conclusion, we believe there is an urgent need for all clients who are battling with addiction issues and related problems, particularly those with concurrent disorders, to receive adequate and appropriate services. Clearly stated, this means developing a continuum of care with a range of easily accessible services and where mental health and addiction services aren't siloed and aren't stigmatized; help and assistance through a deep understanding of addiction issues, particularly at the front line, which meets the individual needs of the client where that person lives, in a timely manner, using well-trained staff, coordinated access, navigational support and an urban/rural system flexibility.

In order to finance the needed changes, we suggest as one example that the government take more money out of the profits realized by the promotion of gambling and apply these funds to mental health and all kinds of addictions. For numerous reasons, not the least of them stability and planning, it is also critical that the govern-

ment provide agency funding for periods of at least three years.

Thank you to all of you for your marathon of going across Ontario to listen to people like us, for coming to our region, and thank you for your commitment to developing a client-centred 10-year plan to strengthen mental health and addictions services across Ontario.

We right now would, we hope, have some time left, and be happy to answer your questions.

The Chair (Mr. Kevin Daniel Flynn): Yes, we do have a little bit of time left, about a minute and a half for each. Let's start with France this time.

M^{me} France Gélinas: I'll be very brief. You've talked about wage parity. Right now in Ottawa region, where would the mental health worker in a community agency fare vis-à-vis somebody working in a hospital?

Mr. Mike Beauchesne: In our experience—and I work in a youth-related sector—we're looking at about a 20% difference in terms of comparable staff members.

M^{me} France Gélinas: And could you give me an idea of the salary range?

Mr. Mike Beauchesne: Sure. It would not be unusual for a starting counsellor—and this would be someone who often comes in with a university degree as well as perhaps a graduate degree—to be making in the range of \$18 an hour on a contract basis. Compare that with some of the individuals we're losing who are making twice as much as that in some situations, with more job security and benefits to go along with that salary.

M^{me} France Gélinas: What would you say the percentage of unionized positions is within the community mental health sector?

Ms. Lise Laframboise: In the mental health sector? In the mental health sector we wouldn't necessarily be able to answer, since we're addiction.

M^{me} France Gélinas: Addiction; sorry.

Ms. Lise Laframboise: Very few unionized across the addiction sector in the Champlain region.

Mr. Mike Beauchesne: It would be quite low.

Ms. Lise Laframboise: Maybe 5% or 10%?

Mr. Mike Beauchesne: Maybe in the 5% to 10% range.

M^{me} France Gélinas: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Any questions from this side? Liz?

Mrs. Liz Sandals: Yes, a couple of questions. One, you talked about people who are having to deal with a concurrent diagnosis but the counsellors really don't have concurrent training. What would be the ideal training for somebody to be able to deal with both addiction and mental health? Where would you like to see that evolve?

Ms. Lise Laframboise: At this time, there are various concurrent disorder training certificates available, but it's a matter of being able to cover the staff time to attend those types of certificate trainings, which are often 10 days in length. So it's being able to cover staff time and travel. For example, in Renfrew county we would need to be travelling down to an Ottawa area to obtain that kind of training. So you're looking at, possibly, with

the residential service that we have, having to backfill, and then just on top of being away from the office for the day and all that kind of stuff—

Mrs. Liz Sandals: So the training is available. Because you then go on in your recommendations to talk about needing to land on a standard for the certification, which led me to believe that perhaps there isn't the recognized training—

Ms. Lise Laframbroise: There's certification in addictions. I'm not sure about mental health, but there is a certification that's recognized in addictions, which takes just over three years to obtain and a great deal of training.

The Chair (Mr. Kevin Daniel Flynn): Sylvia.

Ms. Sylvia Jones: Thanks for your presentation. You have touched on an issue that we've heard over a number of presentations, and that's the need for coordination. I'm going to ask Lise and Mike, particularly, because you deal with youth. At this stage, how are you doing that coordination from transitioning from youth into adult?

Mr. Mike Beauchesne: That happens in numerous ways, but most predominantly it's through coordinating of groups such as the Champlain Addiction Coordinating Body, working with our mental health partners as well as the other partnering sectors—the schools, criminal justice—but mostly just through direct conversations with our service providers and keeping close-knit conversations ongoing with those groups. That's really essential.

Youth is a specialization with unique needs, and I think we're getting more and more to the point where that's being recognized. Also, I think it's being recognized that putting the investment in when these individuals are younger really has tremendous benefit over the long term. That seems like a common sense notion in many respects, but it's not always something that has been acted upon.

Ms. Lise Laframbroise: We deal with 16 and over, so we have only 0.5 FTE for the entire county of Renfrew to deal with youth. Once they turn 16, then they can access other services. I believe that here in the whole Champlain district, youth is quite underserved, so we certainly could use more monies being funded into our youth and prevention. Not many of the agencies in the Champlain region are funded to do prevention or early education.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today. Thank you very much for your presentation.

ONTARIO PUBLIC SERVICE EMPLOYEES UNION

The Chair (Mr. Kevin Daniel Flynn): Our next presentation this afternoon is from the leadership of the Ontario Public Service Employees Union: Mr. Thomas, the president, and David McDougall, the president of Local 439. Please come forward and make yourselves comfortable. Okay. You know the rules: 15 minutes, use

it any way you see fit, and if there's any time at the end we'll use it.

Mr. Smokey Thomas: Thank you. It's a pleasure to be here. My name is Smokey Thomas, and today I have with me David McDougall. David is the president of OPSEU Local 439 at the Brockville Mental Health Centre, the former Brockville Psychiatric Hospital.

In our union, we have 130,000 members. We all work in the public service, and about 30,000 of our members work directly in health care, either in clinical or support situations. Also, we have several OPSEU activists with us who work in mental health, and they're interested in what we have to say and what's going on. We have 7,500 members who work directly in mental health, and we believe that we know the issues as well as anyone, and for a very good reason: Our members are nurses, psychologists, social workers, occupational, recreational and child therapists, who work alongside clients to strengthen their lives. We work in institutions and the community. In fact, it was the psychiatric hospitals that started the move to the communities about three decades ago.

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We're the carpenters, the plumbers, the electricians, people who keep the physical plants operating. I'm a registered practical nurse—I haven't been on a ward in years, mind you; I've been in the leadership of OPSEU for a few years—from the former Kingston Psychiatric Hospital. I actually started there when it was still called the Ontario Hospital. So I've been around since about 1971 in mental health. That's the only thing I've ever done in all my adult life other than union. I must say that over the years in OPSEU we've been very much involved in mental health issues: in 1980, Ontario's Mental Health Care Breakdown; in 1983, Recipe for Restraint: A Discussion on Mental Health; in 1985, Where Are They Now?, a report on deinstitutionalization—two of those; and in 1994, Mental Health Reform in Ontario: Developing our Vision. We go way back even earlier than that into the 1970s. Based on that, I believe we have credibility when it comes to mental health issues.

I read the discussion paper, Every Door Is the Right Door: Toward a 10-Year Mental Health and Addictions Strategy. It's my understanding that this paper will help frame many of the key issues your committee is studying before your final report. At the outset, let me say that it's hard to quibble with the goals set out in the discussion paper. They're very good goals, very lofty goals, and, we hope, attainable.

We all seek to identify illnesses and intervene appropriately. Who among us wouldn't want superior-quality care? I regret to remind you of one thing, though: Health Minister Caplan's advisory group was composed of 24 individuals. None of them were from organized labour, and we think that's a travesty. We believe that the absence of labour's voice in that group was a mistake and we certainly believe that we would have had a lot to add. But, with that being said, I was especially attracted to

section 4 in the discussion paper, which talks about strengthening the workforce. I have quite an interest here.

The report says all the right things. It talks about skilled workers on the front lines with adequate capacity. It talks about improving recruitment and retention of skilled workers while enhancing competency in the community sector. We agree.

In other words, it repeats the same goals and objectives that OPSEU has been saying to governments and review panels for the past 30 years. I've seen a lot of these committees come and go; I've read the recommendations. I've been doing it for a long time. Still, the need for community mental health and institutional mental health has never been met.

So it's sad to say that I sit before you today to make the case that by closing the Brockville Mental Health Centre and transferring beds to Ottawa, this government is undermining everything that it claims will strengthen the delivery of mental health care services. Let me remind you of the facts.

The Brockville Mental Health Centre is scheduled to close by March 2011. If this goes ahead, as many as 450 well-paying jobs—is it?

Interjection.

Mr. Smokey Thomas: Close—will be lost to that local economy that has already been battered by the deindustrialization of the St. Lawrence Seaway. They'll be lost to that community. Sixty-four transitional beds will be transferred out of Brockville, thereby depriving a community of 22,000 of a vital local treatment service for the most vulnerable people in our society. And all this at a time when we're supposed to be experiencing infrastructure building. The government is dismantling a vital part of the local infrastructure. Worst of all, it's being orchestrated by the local health integration network of southeastern Ontario. This is a politically appointed, unelected, unaccountable body, and it's making decisions that adversely affect community-based patient care while at the same time weakening the local economy by tossing away these skilled jobs.

To add insult to injury, the CEO of the Royal Ottawa Health Care Group has said publicly and to us directly that he will not implement a human resource labour adjustment plan to accommodate those Brockville workers who say they are prepared to follow their jobs to Ottawa.

Then there's the matter of money. It will cost \$26 million to eliminate the jobs, but it would only cost \$20 million to refurbish the Brockville unit, thus preserving jobs and the services in the community.

If you add it all up, is this how we want to build stronger mental health and addiction services to meet the needs of our communities? Is this how we strengthen regional infrastructure? Is this how we deal with workers and clients in the face of recommendations from the minister's own advisory group that calls for more trained workers working under conditions that make services more accessible and integrated to those in our communities who need them most?

My answer to that, and the answer from our members in Brockville, is clear: We do not accept that by closing down the Brockville Mental Health Centre we would be improving local mental health treatment. We do not accept destroying 450 jobs. We do not accept that the lives of workers and the treatment of patients should be tossed overboard by an unelected body who needn't justify their decisions in the court of public accountability.

We're calling on the Ministry of Health and Long-Term Care to order a one-year moratorium on any further hospital closures pending the outcome of the minister's task force on the delivery of health services to northern and rural communities.

Our position is consistent with the Ontario Medical Association and the city council of Brockville. Both groups support a one-year moratorium.

Let me conclude by saying this: Each of you on this special legislative committee represents a local community at Queen's Park. Each of you is sensitive to the many needs of your local communities, and it's fair to say that most of you would resist losing a valuable public service that meets the need of your local community, especially in the face of public opposition.

These are the benchmarks we are applying to the proposed closing of the Brockville Mental Health Centre.

We would hope that you will support the community by saying no to shutting down local mental health and addiction services.

Your choice is clear: You're either on the side of building capacity to meet local needs, as OPSEU and other groups have been advocating, or you're on the side of separating local services from the needs of local communities. In my view, there's not much middle ground.

With that, I thank you for hearing us out, and we will answer any questions.

The Chair (Mr. Kevin Daniel Flynn): Wonderful. Thank you, Smokey. You've left a lot of time, so let's start with this side. We've got two minutes. Any questions from that side?

Maybe I can start with one, just so I'm more familiar with the centre itself. Just how old is it as a building?

Mr. Smokey Thomas: The buildings would vary in dates. Some would be from the 1960s; some would be from earlier. What's left to occupy would be from the late 1950s, early 1960s.

The Chair (Mr. Kevin Daniel Flynn): How would it compare to the facility in St. Thomas, for example? Around the same era?

Mr. Smokey Thomas: Probably, yeah. A lot of them were built in the 1950s and 1960s. Kingston opened in 1959.

The Chair (Mr. Kevin Daniel Flynn): Good. Are there any questions from that side? Maria?

Mrs. Maria Van Bommel: I just wanted to clarify it, because as I look through both your presentation and the press release, you use the number of 250 jobs.

Mr. Smokey Thomas: The number's wrong. That would be about full-time equivalents, but there are a lot

of people who work half-time, part-time, so it's more than the 450.

Mrs. Maria Van Bommel: Okay. So that explains the difference. Thank you. That clarifies it for me.

The Chair (Mr. Kevin Daniel Flynn): Questions?

Mrs. Christine Elliott: Just a factual question, Mr. Thomas. Does the centre right now offer both mental health and addiction treatment services, both locally and regionally, or what kind of a population does it serve?

Mr. Smokey Thomas: They have a dual diagnosis unit.

Mr. David McDougall: There's some limited—not a lot. There's a little bit.

Mrs. Christine Elliott: And that's both for local—and is it a regional centre still? I know it used to be, but is it still operating in that way?

Mr. Smokey Thomas: Yes. Each psych hospital still has a catchment area. So Brockville serves a catchment area. It doesn't line up totally with LHINs. More than one LHIN can be involved in a catchment area of a psych hospital, which is a problem for the psychiatric hospitals actually because then you've got two groups that you supposedly don't report to but you do report to.

Mrs. Christine Elliott: Just one other question. What's the stated reason for closing it down and transferring to Ottawa?

Mr. Smokey Thomas: The current administration of the Royal—they go back to the restructuring commission reports of the mid-1990s. There was a reason that nobody implemented those restructuring commission reports on Brockville: because it didn't make sense then and it doesn't make any sense now. That's the rationale being used.

The public rationale from the CEO is that the buildings are too old and too decrepit to be occupied, but in the next breath has said that the federal government is perhaps going to move female offenders into these buildings. If the buildings aren't good enough for psychiatric patients, why would we consider that they would be good for female offenders requiring treatment?

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What I've witnessed about mental health all across the province is that each time after divestment the receiving hospital gets the money. The money was supposed to be protected, but it turned out that the Honourable George Smitherman—I don't know if he was mistaken or misled us, but the money envelope was only protected for a one-year period. So in London they took millions of dollars from mental health, and pumped it into other parts of the service. We see it in Kingston, we've seen it in North Bay—everywhere. It's one thing to say that you're going to take money out of the institutional budget and use it for other things, but if it's being used for things that weren't mental health, then mental health services are suffering.

The presenters before us said that there is a wage discrepancy in the community, and there is. It's very difficult to keep qualified people in the community when there are such wage discrepancies.

The promise from all three parties when in power was that mental health dollars were almost sacred. As the institutions closed, all those would be transferred dollar for dollar to the community. That has not happened by any political party in power, and I'm the person who was fighting the NDP in power that created the—and we finally agreed to shut our mouths and leave them alone. In exchange, they would create the community reinvestment fund. When it came out, it was \$250,000, and then they got defeated and the Tories never transferred hardly a penny. Frankly, the Liberals have done even less.

The local health integration networks, I would submit respectfully, do not understand mental health. Even everything the government has done to this day—to say that you can develop a 10-year strategy and not talk to the front-line workers makes absolutely no sense to me at all because you lose the input of the very people who work on the front lines, who tell you, "This will work. This won't."

I've been doing this since the 1970s. I've been on panels. I've gone to two-day strategic planning sessions under three different governments, all kinds of stuff, but what happens really and truly at the end of the day is that the clients, the consumers of the service, are only paid lip service and the people who actually work in the system who agree with the clients don't even get a seat at the table.

It's just an ill-thought-out plan. We would hope that the government would say, "A one-year moratorium on any further closures." We've been asking for this for years in the psych hospitals: "Please don't close any more beds until the community is adequately resourced." And that is not too much to ask.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Smokey. France?

M^{me} France Gélinas: When you say "64 transitional beds," those are the only operating beds left at Brockville?

Mr. Smokey Thomas: No. There would be the equivalent of an admitting unit, which is supposed to be transferred to Brockville General Hospital. However, they won't take it until they get capital funding to renovate the whole hospital, not just a ward. They want to renovate the whole hospital. Sixty-four beds—they're stopped readmitting and they say they can go elsewhere, but it's not that simple. That's not how it works. If you've been a patient in Brockville and you live in Brockville's catchment area, you can't just wander off to Kingston and get readmitted if you need readmission.

They did this in developmental services in those institutions. They went, "No more readmissions." Where do you go? You're not going to get into Kingston; Kingston runs at capacity.

Again, the notion, as the CEO said to us when they finally did have a meeting with us to tell us their plans, "They'll find somewhere to go," seems pretty callous to me. There's really nowhere. There will be something left in Brockville, but really, it's homeless right at moment. I'm not aware of any capital dollars for Brockville

General Hospital on any build list anywhere. You know what I mean? You don't just get \$5 million, \$10 million, \$15 million for that. So that's a problem as well. They may not be able to close it. So all their plans may be for naught.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today. Thanks for your presentation, and to the other members who attended with you.

Mr. Smokey Thomas: Thank you.

CANADIAN MENTAL HEALTH ASSOCIATION, CHAMPLAIN EAST BRANCH

ASSOCIATION POUR LA SANTÉ MENTALE, CHAMPLAIN EST

The Chair (Mr. Kevin Daniel Flynn): Our next delegation this afternoon is from the Canadian Mental Health Association, the Champlain East Branch, Michael Lloyd, Roger Villeneuve and Sylvie Lemaire. If you'd like to come forward and make yourselves comfortable, you have 15 minutes like all the other groups. Use that any way you see fit. The microphones work best when you stay about a foot away from them.

M. Roger Villeneuve: Good afternoon. Bon après-midi. Mon nom est Roger Villeneuve. Je suis président de l'Association canadienne pour la santé mentale, Champlain Est. Je suis ici avec Michael Lloyd, directeur général, et Sylvie Lemaire, directrice des programmes. Je suis certain que vous avez déjà entendu dire que les personnes vivant avec une difficulté de santé mentale sévère et persistante ou concomitante ont besoin d'un foyer, de travail et d'un ami. Ces besoins sont universels. La gestion de cas intensive ainsi que le soutien par les pairs peuvent épauler un individu à atteindre ses buts de se rétablir.

Fournir ce soutien est primordial dans un secteur rural ainsi que dans la plus grande concentration de population francophone de l'Ontario et comporte des défis considérables. ACSM Champlain Est comprend trois équipes de gestion de cas intensive, ou équipes GCI. Chaque équipe a son superviseur d'équipe et huit employés de GCI. Ces équipes sont situées à Cornwall, à Hawkesbury et une équipe satellite est répartie dans les comtés en quatre bureaux. De plus, nous dirigeons trois centres de ressources pour les pairs situés à Cornwall, à Hawkesbury et à Casselman. Un quatrième superviseur d'équipe gère ces trois centres. La filiale est orientée sur le rétablissement et elle a adopté une philosophie de difficultés concomitantes, ayant une approche portes ouvertes.

Au cours des trois dernières années, nous avons développé de la formation et des services en difficultés concomitantes. Tout le personnel de GCI a reçu de la formation mutuelle en toxicomanie et 12 de nos employés ont obtenu l'accréditation de conseiller en toxicomanie niveau 2 avec le Canadian Council of Professional Certification.

Champlain Est englobe deux groupes de comtés unis : Stormont, Dundas et Glengarry ainsi que Prescott et

Russell. On les appelle aussi les cinq comtés de l'est. Ils s'étendent sur 5 000 kilomètres carrés, représentant 30 % de la région de Champlain. La population compte 190 000 individus, dont 70 % sont francophones dans Prescott et Russell et dans l'est de SDG. Les défis sont reliés à la pauvreté ainsi qu'à l'ordre géographique, linguistique et culturel. Ces défis sont interreliés, tout est nuancé et rien n'est distinct.

Si on les compare avec les centres urbains, les difficultés géographiques sont le transport, plus de préjugés et ressources communautaires restreints en services externes et services à domicile. Nos équipes de GCI sont mobiles, et cela augmente les déboursés pour les coûts de transport pour desservir les cinq comtés. Les petites communautés requièrent de l'assistance pour fournir un accès juste et équitable aux éléments déterminants de la santé. Modifier le programme d'initiation pour les sans-abri pour inclure les propriétaires pourrait s'avérer une solution possible.

Dans le milieu rural, la stigmatisation est plus considérable que dans des grands centres urbains car l'anonymat est difficile à conserver dans le cadre d'une petite communauté où tout le monde connaît tout le monde et leurs problèmes. Ceci a pour résultat que les individus consultent hors de leur communauté ou ne consultent pas du tout. La réalité de la pauvreté étant reliée à la santé mentale, une grande majorité d'individus ne possèdent pas de véhicule, et ce facteur d'isolement réduit l'accès à un réseau de soutien qui peut les assister dans leur rétablissement. Même s'il y avait un service de transport, ces individus n'auraient pas les moyens de se le payer.

En réponse à ce problème, la filiale a commencé un programme de transport gratuit qui est incorporé dans le programme de soutien à l'emploi. Il procure à nos clients ruraux le transport pour accéder à nos centres de ressources par les pairs, ce qui leur permet de socialiser et d'acquérir de bonnes habitudes de vie, se rendre à leurs rendez-vous médicaux et acheter de l'épicerie et ainsi de suite. Les conducteurs sont des clients du programme de soutien à l'emploi. Ceci les responsabilise, favorise l'autonomie et leur procure une expérience de travail. C'est un tremplin pour l'emploi à l'extérieur de la filiale. Présentement, ce service n'est pas subventionné par le RLIS de Champlain.

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Les initiatives de client : suivance ne sont pas toujours faisables ou pratiques dans un cadre rural. En plus, de la stigmatisation croissante est peut-être difficile pour des groupes de gouvernance de se rencontrer à cause des grandes distances à parcourir sans moyen de transport.

La filiale dirige des centres de ressources par les pairs qui sont menés par des intervenants et intervenantes en soutien par les pairs et supportés par le personnel de GCI, qui en accroît la capacité de manière soutenue.

Les centres de ressources par les pairs et le service de gestion de cas sont interreliés, fournissant l'accès simplifié aux deux services et procurant un continuum de soin. Ceci permet au personnel de GCI de fermer les

dossiers des clients plus rapidement lorsque les besoins de ces clients sont comblés et qu'ils sont stabilisés, car leurs progrès peuvent être surveillés aux centres de ressources par les pairs, en plus du système de suivi de fermeture en place pour tous les services. La durée moyenne de la gestion d'un client par notre service de gestion de cas permet au personnel de GCI de servir plus de clients et de maintenir une pratique sans liste d'attente.

Dans les secteurs ruraux, il n'est pas réaliste d'avoir des services de gestion de cas intensive spécialisée telle que la déjudiciarisation ou une équipe de soutien au logement et ainsi de suite. Notre personnel de GCI a besoin de répondre à tous les aspects des besoins du client. C'est accompli en utilisant l'approche holistique. Ceci requiert plus de financement pour la formation. Afin d'offrir l'expertise, la filiale a sélectionné et formé le superviseur d'équipe et les membres du personnel chargés du programme, visant spécifiquement les projets suivants : ils sont difficultés concomitantes, soutien à l'alcool, déjudiciarisation, soutien au logement, soutien à l'emploi, vieillir à la maison, diagnostic double, soutien à la famille et soutien informatique. Ceci permet à chaque GCI de procurer tous les services avec le soutien du chargé de programme de son équipe afin d'assister lors de situations plus complexes.

Pour approfondir l'approche holistique, nous croyons qu'une masse critique de services devrait être créée pour assurer un continuum de soins entre les services en milieu rural. Des services de l'équipe communautaire de traitement intensif et des services de crise devraient être joints aux services de GCI. En ayant des équipes TCA et des services de GCI sous une structure gouvernante, le flux de clients en continuum serait moins compliqué et plus centré sur le client.

Les services de crise ruraux n'ont pas le volume d'appels pour garantir un service autonome et devraient être intégrés à l'équipe GCI, où tous les membres du personnel soutiennent déjà leurs dossiers respectifs et tous répondent aux crises dans leur secteur géographique respectif; par exemple, l'hôpital de Pembroke.

L'ACSM de Champlain Est a été l'une des premières agences désignées sous la Loi des services en français dans notre région, et nous maintenons une capacité de services francophones plus élevée que la demande pour ce service. Afin de s'occuper du contexte linguistique et culturel de certaines régions—les cinq comtés de l'est qui ont jusqu'à 70 % de population francophone—l'ACSM emploie du personnel francophone qui livre un service bilingue de façon à ce que nous ne négligions pas la population anglophone.

Tout le personnel travaillant dans ces régions est francophone, du front à la directrice des programmes. Trouver de la formation qualifiée en français crée aussi des défis et augmente les coûts.

Nos recommandations : renforcer les approches de portes ouvertes et le rétablissement à tous les niveaux de nos services; établir des repères pour tous les services en santé mentale et toxicomanie en considérant le fardeau

supplémentaire du cadre rural; élaborer et financer une campagne anti-stigmatisation pour les régions rurales, visant le manque d'anonymat dans le cas d'une petite communauté; créer plus de programmes de ressources par les pairs pour permettre une fermeture de dossiers plus rapide du programme de la gestion de cas intensive, ce qui permettrait à un plus grand ratio de clients par GCI de recevoir des services; créer plus de flexibilité avec les politiques de programmes gouvernementaux; assister les communautés à fournir un accès juste et équitable aux éléments déterminants de la santé; utiliser une approche holistique pour les services ruraux—chaque membre du personnel de GCI fournit tous les services au lieu d'équipe spécialisée; créer une masse critique de services pour assurer un continuum de soin entre les services en milieu rural; et les services d'équipe communautaires de traitement intensif et les services de crise devraient être joints aux services de GCI.

En conclusion, des personnes vivant avec une difficulté de santé mentale sévère et persistante ou concomitante ont besoin d'un foyer, d'un travail et d'un ami. Nous espérons que vous remarquez les défis liés à pourvoir des services dans les régions rurales qui nécessitent une approche compréhensive et holistique. Merci. Thank you.

The Chair (Mr. Kevin Daniel Flynn): Merci, Roger. First, you've left about five minutes. The first question this time is either Christine or Sylvia.

Ms. Sylvia Jones: Thank you. One question on your second recommendation: You mention establishing benchmarks for all mental health and addiction services. Can you expand on how you would see those benchmarks being laid out?

Mr. Michael Lloyd: We've had different committees work on these things in the past. The last one was the mental health implementation task force, where they came out with benchmarks in different communities. Certainly, we did that in our area. But what we think we need is to know how many intensive case managers per population, right down to psychiatrists and peer support workers. If we could have benchmarks, then we have something to go towards.

The Chair (Mr. Kevin Daniel Flynn): France?

M^{me} France Gélinas: Je vais commencer par vous remercier d'avoir fait votre présentation en français. Vous êtes les premiers, les braves, à l'avoir fait et on a entendu des centaines, donc je l'apprécie beaucoup.

J'aimerais que vous partagiez avec moi—quand on parle de santé mentale et de toxicomanie, être servie dans ta langue est important. Est-ce que vous avez des données probantes qui pourraient démontrer ça, que le fait que vous êtes capable d'offrir des services en français à 70 % de la population qui est de langue française est un avantage?

M^{me} Sylvie Lemaire: Sur le plan de l'évaluation de nos services, on a des sondages qu'on fait puis ça, c'est une des remarques qui revient souvent, qu'il est apprécié d'avoir le service en français, dans leur langue.

M^{me} France Gélinas: Et du côté clinique, est-ce qu'on est capable de prouver que ça fait une différence?

M^{me} Sylvie Lemaire: [*Inaudible*] citer les lignes, mais je pourrais être convaincue, personnellement, étant francophone, et toi-même, quand je me fais servir en français, surtout si je ne me sens pas bien.

M^{me} France Gélinas: Est-ce que vous savez si dans la région d'Ottawa—on a quand même entendu de différentes agences qui sont venues nous présenter. Est-ce que vous savez si les services sont disponibles en français, les services spécialisés que l'on retrouve surtout à Ottawa?

M^{me} Sylvie Lemaire: Ils ne sont pas tous accessibles. Tu as peut-être des employés qui peuvent communiquer en français, mais ils ne sont peut-être pas disponibles quand une personne est là, alors je ne pourrais pas parler pour exactement leur nombre. Je peux parler pour nous. Je sais qu'on peut t'offrir à n'importe quel de nos bureaux, soit à Hawkesbury ou à Cornwall ou n'importe où. N'importe où que tu rentres, par quelle porte tu rentres, tu vas avoir quelqu'un qui va parler en français.

Le Président (M. Kevin Daniel Flynn): Merci, Sylvie. Jean-Marc?

M. Jean-Marc Lalonde: Merci de votre présence et d'avoir pris le temps de venir nous parler de ces centres de ressources dans la région de l'est, que j'appelle le « Far East » des cinq comtés. Je suis très intéressé à savoir si nous détenons un centre de toxicomanie dans les cinq comtés en français, un centre francophone?

M^{me} Sylvie Lemaire: Juste francophone ou qui donne des services en français?

M. Jean-Marc Lalonde: Francophone.

M^{me} Sylvie Lemaire: Juste francophone. An addiction centre where only French is spoken.

Mr. Jean-Marc Lalonde: A French addiction centre. We don't have that in the five counties?

Mr. Michael Lloyd: Not that I'm aware of, no. They're developing a youth one—

Ms. Sylvie Lemaire: Just French.

Mr. Michael Lloyd: —with five beds for a French unit.

Mr. Jean-Marc Lalonde: This has been a complaint, really, that I've been getting at the office from families. When I look at Hawkesbury, for example, it's 95% francophone and 20% of the people do not speak French.

Puis je dois dire que dans les régions rurales, le besoin diffère du besoin du secteur urbain.

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Dans le transport, j'aurais une question. Nous avons mis à la disposition des vans pour « Vieillir chez soi ». Est-ce que nous nous servons de ces vans-là pour des cas semblables, pour se rendre aux centres de ressources dans les cinq comtés?

Ms. Sylvie Lemaire: The vans are only being used for the elderly; they're not being used for mental health, as far as I'm aware.

Mr. Michael Lloyd: The vans that were under—

Ms. Sylvie Lemaire: Aging at home.

Mr. Michael Lloyd: —the aging-at-home project?

Mr. Jean-Marc Lalonde: Yes.

Mr. Michael Lloyd: They're mainly for the elderly. They don't involve our program.

Mr. Jean-Marc Lalonde: I know definitely they've been using those vans to do their groceries instead of having them service the people who need to go to a doctor. In this case, we have people who are seniors who need your help, and those vans are not being utilized properly.

Mr. Michael Lloyd: Well, our clients wouldn't fit into that program anyway because they're mainly for people going from hospital to a doctor's appointment. They don't have any money for it, and our drop-in centres or peer resource centres are not classified as a medical appointment. That's why we set up our own service.

The Chair (Mr. Kevin Daniel Flynn): Thank you. Your time is up. Thank you very much for coming today.

Ms. Sylvie Lemaire: Thank you very much.

Mr. Michael Lloyd: Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you for making your presentation.

M^{me} Sylvie Lemaire: Merci.

M. Michael Lloyd: Merci.

Le Président (M. Kevin Daniel Flynn): Merci.

PSYCHIATRIC SURVIVORS OF OTTAWA

The Chair (Mr. Kevin Daniel Flynn): Our next presenters this afternoon are the 2:15 group, the Psychiatric Survivors of Ottawa. Sonja Cronkhite and Tyrone Gamble, if you'd come forward. Make yourselves comfortable. I see you have some water already so you're all prepared.

Ms. Sonja Cronkhite: We have to be ready. We know we're the post-lunch-lag spot.

The Chair (Mr. Kevin Daniel Flynn): Every group is getting 15 minutes, Sonja, so use that any way you see fit. If you do want to leave some time at the end, that would be great as well. It's all yours.

Ms. Sonja Cronkhite: We'd like to speak with you about peer support, what it is and why it's important in mental health. Tyrone and I are both individuals who have experienced mental health and associated challenges first-hand and we've both sought peer support as a cornerstone for our recoveries. This search has led us to become involved in our local consumer survivor initiatives—I don't know if the group are familiar with those so far—where we were able to hone our skills and build confidence. Tyrone is now a board member of Psychiatric Survivors of Ottawa and I'm now the program coordinator.

I'll start out with a bit about my story. I, like many people in the mental health system, saw myself as a recipient of services. My view of myself was that of a sick, problem person and this view was really reaffirmed daily in almost all my relationships. Everything was all about my problems, my symptoms and my failures, and how they should all be handled. Service providers, family, friends, even my teachers—I became unwell

quite young, in high school—they all kind of joined in with their agendas of what I needed to become well or at least not to harm myself or someone else. I was seen as someone sick who would always need to be taken care of.

Then one day I met a group of women in a whole other context, outside of the mental health system, and these women really changed my life. I told them about my illness but they chose not to interact with me in that role: me being the sick person, they being people who responded to the sick person. They treated me as a friend with whom they were going to exchange ideas, make plans. I was expected to contribute. We were talking about environmentalism and feminism at that age in our lives and we were all really stirred up. We were talking about analyzing systems and having a lot of fun.

It was really different for me. I was expected to bear my share of the responsibility for these friendships, and I did that at that point because I loved what we had together. It was something that really had value for me. They helped keep me alive through some of my crises—I don't know that I would have survived otherwise—and I helped them through their crises. Theirs were different; they were talking about custody battles and whatnot. But our job was to support each other through those things.

Then I was reminded of the pleasure of mutuality, that there's a give and a take in really treasured relationships. Suddenly—well, it wasn't suddenly. Over time I realized I was no longer a needy psych patient, and I really fell in love with peer support.

At Psychiatric Survivors of Ottawa and the other valuable consumer-survivor initiatives, this is our passion. This is where it starts. When mental illness defines your roles and your relationships, it's really difficult to start your recovery journey towards your life as a full citizen. We all need relationships to grow and learn if we're going to reach our full human potential. I'm not there yet, but it's coming. Peer support provides an intentional framework to build and inform these relationships between users of the mental health system to mutually move towards our potential.

These peer-run, minimally funded organizations do a lot for peer support in our community. Psychiatric Survivors of Ottawa runs peer support and peer recovery groups; women's groups; a wellness recovery action plan that provides tools for self-mastery over symptoms and crises; Pathways to Recovery to redefine our post-patient identities, as that relationship did for me; activity groups, informal peer support in the drop-in and our Peer 2 Peer Wellness program.

At PSO, Psychiatric Survivors of Ottawa, we train peers in the philosophy and skills of peer support, and then we match people up with in-patients from the Royal Ottawa Mental Health Centre, so when they're discharged, they have a connection with a peer in the community. They can have that relationship that brings them out, and they have a place to grow from. Our initial research and experience have shown us that these peers do very well when discharged from hospital.

People who were working in the hospitals were a hard sell on this project in the first place: "So we're matching our patients up with crazy people?" I can tell you, the staff in the hospital are amazed at the differences in the people who have been matched up versus the people who they used to see coming back in all the time.

I'm going to turn it over to Tyrone for a while.

Mr. Tyrone Gamble: Good afternoon. Like many others, I became stuck in my illness, hopelessly lost to it. I was overwhelmed by my illness, its associated challenges and the mental health system. After all the little losses and giving up pieces of my life and myself, I developed hopelessness and learned helplessness, losses to my identity, freedom, personal responsibility, accountability, social network and my abilities and capabilities. I became the sum of all my losses and failures.

Those around me managed and discerned my care, treatment and manner of living through various means, from suggestion and persuasion to outright coercion. They became the final arbiter of what was best for me. Their priority was my stability and continued existence. Some of them were merely content that I was basically alive. They did not understand that it is simply not enough to be alive. I was alive, but I had no life. I merely existed. I became the living dead, a soulless automaton. This was my existence for many years until I stumbled upon peer support.

None of my health care providers ever told me that peer support existed. The option was never presented to me. I had to learn about it on my own. I had to learn to navigate the mental health system on my own, even if it was by accident in the beginning. The first thing I was struck by in peer support was the way people related and interacted with one another. It was totally egalitarian. No one had greater authority than anyone else. I was given the opportunity to once again have mutually beneficial and reciprocal relationships. I was offered interdependent relationships instead of the dependent ones I had become accustomed to. In short, they treated me like a fully capable and competent person—a human being. It was liberating to have these types of relationships and interactions.

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Peer support was a humanizing experience. I was no longer a label, but a person. My peers treated me with the dignity, respect and the unconditional high regard one person has for another simply because they are a human being. There was no judgment about my decisions or me. They also respected my right to make decisions and be personally responsible for my care, treatment, recovery and life. In return, they expected me to follow and practise these principles and attitudes and to reciprocate what I was given. I had to choose to be a part of and help build the community.

Peer-run consumer-survivor initiatives such as Psychiatric Survivors of Ottawa and Mood Disorders Ottawa introduced me to the idea of recovery. It filled me with hope that I could have a meaningful life, a life beyond my illness, one in which I could reach my full potential. In order to help me achieve this, these groups

helped me to learn and apply many skills. The programs also helped me to begin to see myself in terms of strengths rather than deficiencies. As a result of these programs, I became personally responsible and accountable for my recovery.

After being a part of peer support for a while, I decided to become a peer supporter. In the peer supporter training, I learned that I had experience and expertise to offer others. I discovered that I am a specialist in survival, recovery and humanizing mental illness and its associated challenges. It is a specialization that gives me, as a peer supporter, a unique role within the mental health system. It allows me to journey with peers in need in a way that other mental health providers cannot in a multitude of situations, a way that many individuals struggling with mental illness have found tremendously beneficial.

It has been a shock to me to discover the lack of support and funding for peer support, especially since it has been so instrumental in not only my wellness, but also in the wellness of others I know personally. I cannot believe that it doesn't have a recognized and respected place within the mental health system. This is surprising, as I have seen the great need for it in my past work in the human services, including working in emergency shelters. Most people do not realize the need for peer supporters and consumer mental health workers in shelters, hospitals, mobile crisis units, community centres, drop-ins and riding along with police like psychiatric nurses etc. What a difference it would make to have a peer supporter sit with you in an emergency department rather than a security guard.

Across Canada and the US peer support is being given an appropriate and significant place in the mental health system. It is being recognized and accepted for how it can complement other areas and disciplines within the mental health system. More people and professions are recognizing the benefits. Real paid positions on par with other mental health workers are opening up, and more are needed.

It is time to legislate peer support and consumer mental health worker positions throughout the mental health and addictions fields. This legislation will help empower and strengthen the practice of peer support and peer services. Give us and our expertise a place. Consumer-survivor initiatives and others have already created training modules, are building networks of peer supporters and see potential roles for them throughout the system. We need you to recognize the work we are already doing by investing in us.

Ms. Sonja Cronkhite: We have seen and continue to see the tremendous changes in the wellness of peers actively engaged in relationships of curiosity and mutual-ity, relationships without agendas and not centred exclusively on the mental health experience. We watch people expand and build other roles for themselves beyond that of mental patient. This focus on creating healthy community through genuine and mutual relationships is what makes the practice of peer support different from the other services.

Mr. Tyrone Gamble: Peer support is an integral part of a mental health system seeking to improve the health and wellness of its citizens.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much. You've left time for maybe one question. We'll give it a try anyway. France, you're up first.

M^{me} France Gélinas: We have heard a whole lot about peer support, but I would say that you are the group who put it in context the best, and I think I finally get it, so thank you.

My question is, then, in the rollout of this, who would hire the peer support? How would you get paid? Where would the money come from? The money would come from the government, I assume, and then go to—have you figured out that part?

Ms. Sonja Cronkhite: Well, the services are already running. There are hospitals, there are emergency rooms, there are crisis teams. What we're seeing is actually having a role in each of these areas that is specifically for a peer supporter. We also have concerns that there's an understanding of what peer support is on all of those teams. It's not just a cheaper person at the other end of the needle. It's someone who's having a different relationship. We're just talking about embedding it throughout the system. We're talking about support for consumer-survivor initiatives that provide this training, but also that peer support is throughout the system and that it's understood throughout the system and that there's an understood role for it.

M^{me} France Gélinas: So would you see the peer support attached to the client, or do you see it attached to the care provider? The example that you gave—you'd much rather sit in the ER with a peer support than a security guard—rang really loudly.

Ms. Sonja Cronkhite: There are hospitals in Ontario and throughout the US where, if you go into emerg and say you want to see a peer support worker, you'd go into another room, there would be a futon, low lighting and someone who'll sit there and talk with you or just listen to what you need to say. They're often finding that people can go in and talk with a peer supporter, have a cup of tea and can leave and go back to their usual support systems the next day. They find they don't often need medical emergency services. They're in a crisis. They need to be heard. It all depends on why people are there. But there are a number of people who don't need to use emergency services if they can just have someone sit and listen to them for a while.

The Chair (Mr. Kevin Daniel Flynn): Thank you for coming today. It was a great presentation.

Ms. Sonja Cronkhite: This also gave us an opportunity to sit down together and think again about why we do this, so I would like to thank all of you for the opportunity for us to do that, as well.

ROYAL OTTAWA HEALTH CARE GROUP

The Chair (Mr. Kevin Daniel Flynn): Our 2:30 delegation is the Royal Ottawa Mental Health centre. Dr. Zul Merali and Dr. Alison Freeland are with us.

Just make yourselves comfortable. Everybody gets 15 minutes. Use that as you see fit, and if there's any time at the end we'll see if we can split that amongst the groups. It's all yours.

Dr. Zul Merali: Good afternoon. I'm Dr. Zul Merali. I'm the president and CEO of the University of Ottawa Institute of Mental Health Research, which is an affiliate of the Royal Ottawa Health Care Group.

First, I'd like to start by thanking the committee for the opportunity to present. It is a positive direction on behalf of the Legislature to move forward on a much-needed review of the mental health and addictions needs and services of the province. We also commend you on the scope of the presenters and the depth of research the committee is giving out.

As background information, we have provided copies of the brief overview of the Royal Ottawa Health Care Group as well as the strategic plan. This said, I'll only speak briefly about the organization.

The Royal Ottawa is a specialized academic health science centre providing in-patient, outpatient and partial hospitalizations, as well as day hospital programs and research. Our specialized services also extend beyond the walls of our hospital, through outreach mental health care teams, bringing patient care directly to the homes, the community, the hospitals in eastern Ontario and beyond.

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Our integrated clinical and research programs are aimed specifically at treating people with complex and serious mental illnesses which are often resistant to treatment. Thousands of patients are referred to us for specialized care by psychiatric programs in hospitals and communities throughout the region.

To discover new treatments and improve quality of care, we need to invest in research. Through research, we can better understand the causes of mental illness and find ways to detect it earlier and treat it more effectively. The University of Ottawa Institute of Mental Health Research, or the IMHR, is one of the largest research centres of its kind in Canada and a crucial partner of the Royal Ottawa Health Care Group. IMHR has attracted some of the best and brightest researchers from around the world. Research is fundamental to developing excellent mental health services and is necessary to improve the detection and understanding of mental illness, provide a foundation for early intervention strategies, reduce the severity of illness, lead to faster recovery, develop more effective treatments and lead to better and more cost-effective interventions through the use of technology.

Being an academic health science centre, we have a strong capacity in producing new knowledge and translating this into optimal patient care. IMHR's greatest opportunity lies in its ability to work side by side with the professional clinical staff at the Royal Ottawa to develop innovative ways to treat mental illness.

I must stress the positive impact that knowledge transfer and update makes in all areas, including patient care, research, training and education and its link to

academic health science centres. I urge that it strongly be considered in the development of Ontario mental health and addiction strategy.

We cannot forget the important role that academic health science centres play in educating and training future health care providers as well as researchers. The dedicated research teams at the IMHR are rapidly translating findings from the laboratory to the clinic, where new knowledge can and must be used to improve the lives of patients and their families. IMHR's greatest opportunity lies in its ability to work side by side with professional clinical staff at the Royal Ottawa to develop innovative ways to treat mental illness.

A good example of the way that important new discoveries occur and evolve is Dr. Pierre Blier's pioneering work in the medical treatment of depression. He is a holder of the Canada Research Chair in Psychopharmacology. Dr. Blier's success with innovative drug research began with basic research in his laboratory. Promising initial studies led him to conclude that some pharmaceutical combinations promised far greater benefits than traditional single-medicine depression therapy. Financial support was obtained for limited trials on human subjects. When the experimental subjects in those trials experienced more than double the usual remission rate for depression, funding was secured for a study of the size and scope to attract worldwide notice. His work is now funded by the National Institutes of Health, a US agency—a highly prestigious and competitive award.

Today, Dr. Blier is seeking the most effective ways to translate the results of his groundbreaking studies into clinical practice, but he could not have reached this point had he not managed to secure support for his initial laboratory investigations. Obtaining those funds can be an uncertain venture because at that stage, no researcher can honestly claim to be on the verge of a breakthrough. New discoveries are only the first steps in a much longer process, but without them, influential later studies would never emerge.

Thank you for the opportunity to present. I'd now like to ask my colleague Dr. Freeland to address the committee.

Dr. Alison Freeland: Good afternoon. My name is Dr. Alison Freeland. I'm the associate chief of psychiatry of the Royal Ottawa Health Care Group. I'm speaking on behalf of my organization this afternoon.

We are very encouraged to see that this committee is looking at both mental health and addictions within its mandate. It is important that a comprehensive approach to concurrent disorder treatment services is offered in Ontario. I would like to start with this issue within the homeless population and how the Royal is working with other leading organizations to develop innovative approaches to treatment and care.

As I'm sure you've heard, concurrent disorders affect anywhere from 12% to 20% of people in the general population. However, when looking at the homeless population, this incidence rises dramatically to 60%, to 90%. In addition, concurrent disorders in this population

often include serious mental illness. For example, 40% to 60% of the homeless population with mental health problems have a psychotic illness—did I pick the wrong microphone?

The Chair (Mr. Kevin Daniel Flynn): Why don't you sit back a little bit from it and see if that does it any better?

Dr. Alison Freeland: See if that helps?

The Chair (Mr. Kevin Daniel Flynn): Yes. We'll try it, anyway. Everything else we've tried hasn't worked.

Dr. Alison Freeland: Just let me know if it's still buzzing.

The Chair (Mr. Kevin Daniel Flynn): It's research.

Dr. Alison Freeland: As a specialized mental health centre, the Royal has identified the need for development of unique treatment strategies to meet the needs of both the mental health and addiction aspects of the homeless. One of my colleagues, Dr. Susan Farrell, and our psychiatric outreach team are part of a national collaboration funded with over \$2 million by the Canadian Institutes of Health Research, looking to address the mental and physical health needs of the homeless through a longitudinal study of 600 persons in Toronto, Vancouver and Ottawa. We strongly support the need for ongoing development and evaluation of similar multi-site efforts that endorse collaboration between hospital and community as well as between professionals and consumers to continue this kind of work.

Balanced with the need to do research and evaluation in the area of concurrent disorders is the need for knowledge and education with respect to best practices. Concurrent disorder education needs to be accessible to a wide range of providers to assist with the integration of services to support consumers' mental health and addiction issues simultaneously. Effective treatment of concurrent disorders requires a balance between assessment and treatment of both addiction as well as the present mental illness. Our belief is that any provincial strategy that will successfully address this has to provide the resources and expertise to ensure that this balance is successfully obtained. Any strategy focused on providing housing alone for those with both mental illness and addictions will not allow for successful outcomes if the provision of evidence-based treatment and care is not instituted at the same time.

Access to care is another important point to address. Family physicians play a pivotal role through early detection and treatment, but they frequently advocate for the need for access to specialized psychiatric services for consultation and transfer of care, when appropriate. We strongly endorse the need to fund and support models of shared care between family physicians and specialized mental health service providers to improve family physicians' capacity to identify and address early signs of mental illness and addiction as well as to provide care for the high incidence of the physical health problems seen in the concurrent-disordered population.

We must also look at incentives for specialized mental health centres to provide indirect care such as education

and capacity-building to other health care providers so that persons with mental health and addiction issues can be supported in a full range of health care settings. The Royal is doing this through providing community education and training, as well as helping lead the interface between mental health and addictions within our region as we develop and continue to act as a resource and to do training and education in both these areas. We are also using new and emerging technologies such as urgent consultation services to physicians in remote areas through telepsychiatry. Education and training is key in our role as an academic health science centre.

Mental health and addictions system change will require substantial investment and interministerial co-operation. It is important to remember that it is beyond the purview of the mental health system alone to address all of the issues that impact on mental health and addictions, and that lasting system change requires collaboration across services and across ministries.

In the implementation of a new strategy, two key issues must be further considered and addressed. First is the role of the academic health sciences centre to provide integration of research and clinical service delivery with the education of students who receive training to be tomorrow's workforce. Academic health science centres play a critical role in system capacity, strengthening the workforce and creating healthy communities, and their unique role requires further consideration.

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Second, there is a need to ensure that the final framework and strategy address the interface between the hospital and community sector and the important role of the hospital in offering the full continuum of in-patient, outpatient and community-based services.

Once again, we thank the committee for the opportunity to speak to you today. We've tried to be brief. We know there's lots to talk about, but we would be pleased to answer any of your questions or to receive comments or suggestions about further information you might require. Thank you very much.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for your presentation. We'll go to the government, but I had a question, first, that came up just as you were talking. We seem to use emergency rooms as a place where people should go when they're in crisis. As you were saying, and as the previous presenter was making the point, sometimes a cup of tea and somebody to talk to in a nice room changes the world for you. It seems to me that emergency rooms, in a lot of cases, would be the last place you'd want to go. You've got people dying, you've got accident victims coming in, you've got people grieving, and you've got children in pain. If you're in crisis, you'd think it would be the last area in the whole community you would want to be in. Why are we using emergency rooms? How have we got into that situation?

Dr. Alison Freeland: That's an excellent question, and I think that's something that, in terms of a strategy, will require some careful consideration and thought.

If I can just offer a few comments about that: My clinical work is as a psychiatrist with a community-based multi-disciplinary team, and I service people who have serious mental illnesses, primarily psychotic illness. What's really interesting is, when you look at the scope of what a crisis is, we tend to see a crisis—and certainly it can be—as something where somebody feels suicidal or they're hearing voices telling them to hurt somebody else. In those situations, it is safe to ensure that somebody gets to a facility for proper assessment and possible admission. But just as equally, we can get calls in our 24-hour service—because that's what we offer; we have an on-call service as part of our team—where somebody has run out of cigarettes that evening and has no money. For that individual, because of the severity of their illness and difficulties perhaps with paranoia and going to a store and purchasing cigarettes, that is also a crisis and requires a completely different kind of level of intervention. When we're trying to understand crisis, we really need to understand crisis from a person's perspective. Somebody might phone and say, "I'm feeling really, really stressed out," but you need a way for triaging people to the right kind of crisis intervention.

I agree that many people don't necessarily need to go to an emergency room. We do have a range of services that might include things like a mobile crisis team, where people can visit a person in their home and try and understand what the situation is. I am also a very strong believer in peer support services, which you've just heard about in your previous presentation.

The Chair (Mr. Kevin Daniel Flynn): Okay, thanks. I'm going to go back to my colleagues because I think there was a lot of interest in asking questions. Jeff?

Mr. Jeff Leal: I'll be quick, Mr. Chair, because I think Helena wants a quick question.

The Chair (Mr. Kevin Daniel Flynn): Okay, well we've got about a minute and a half.

Mr. Jeff Leal: Closeness to CFB Petawawa—we have men and women in the Canadian armed forces doing four and five tours of duty in Afghanistan. Post-combat stress: Does that put any pressure on the services that you provide and the research that you're doing for these individuals who are returning back home?

Dr. Zul Merali: Yes. As a matter of fact, just recently we opened a stress injuries clinic affiliated with the hospital that deals specifically with that type of clientele. It's a huge need. We have, for example, from the education and research perspective, a symposium coming up in October dealing with post-traumatic stress using research-based strategies in intervention. They're even starting to talk about actually curing post-traumatic stress disorder. So there's a lot of excitement and a lot of need for this area to go further.

The Chair (Mr. Kevin Daniel Flynn): Helena?

Ms. Helena Jaczek: What's happening to the beds that are being closed in Brockville?

Dr. Alison Freeland: Right now, we're in the process, from a patient perspective, of going through each client, meeting with their families, and making individ-

ualized plans in terms of where people would best fit, the goal being to help people return to the community, as most people express a wish to be there from a quality of life perspective, but definitely looking at, in terms of needs and services, where people are best placed.

Ms. Helena Jaczek: So those beds are actually going to be lost? It's not a question of transferring them to Ottawa or to other secured forensic units?

Dr. Alison Freeland: The beds that are closing are being closed at this point.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today—a great presentation. Thanks for your time.

MINWAASHIN LODGE, ABORIGINAL WOMEN'S SUPPORT CENTRE

The Chair (Mr. Kevin Daniel Flynn): Our 2:45 presentation is from the Minwaashin Lodge, the Aboriginal Women's Support Centre. Deborah Chansonneuve, research and development consultant, thanks for joining us today.

Ms. Deborah Chansonneuve: Thank you for having us.

The Chair (Mr. Kevin Daniel Flynn): Make yourself comfortable.

Ms. Deborah Chansonneuve: We always start by welcoming people to the ancestral territory of the Algonquin nation, which is where the National Capital Region is located.

Addictive behaviours and violence against indigenous women and girls are two of the most urgent, widespread and preventable social problems facing our families and communities. The persistence of social conditions such as poverty, marginalization and prejudice helps to perpetuate this intergenerational cycle.

We also always begin with a story, so I'm going to tell you the story of one of our clients that will help illustrate what some of the problems are.

Rosemary T. is from a First Nations community in northern Ontario. Her grandparents on both sides are residential school survivors, as was her biological father. Her mother had been apprehended by the CAS at the age of 11 due to family violence and alcohol abuse. Because of her parents' alcohol abuse, and sexual abuse by her father, Rosemary was also in and out of foster care from the time she was eight.

Rosemary had been in Ottawa for two years when she came to Minwaashin Lodge's emergency shelter at the age of 23, two months pregnant with her fourth child. Though she had tried to quit on numerous occasions, Rosemary was addicted to crack cocaine.

Like Rosemary and her mother before her, her previous three children had been apprehended by children's aid. Rosemary wanted very much to keep her fourth child and worked closely with the shelter staff, with children's aid and with other services to do so. She attended parenting classes, a treatment centre and many other programs throughout the pregnancy. Nonetheless,

CAS still had concerns for the child and apprehended it at birth. The staff members at the shelter were shocked by this, given the number of changes and the progress that she had made. Needless to say, Rosemary was devastated, but slowly, over time, visitation turned into overnights and there was hope the child would be returned to her. Unfortunately, after nine months Rosemary relapsed for two days. Rather than understanding relapse as a normal part of the recovery process, CAS stopped the overnights and reduced the visits. Feeling increasingly defeated and depressed, Rosemary started to miss visits, behaving in ways the children's aid called "uncooperative." Due to the age of the child, and in accordance with risk protocols, CAS went to court, ceased visitation, and once again another child was adopted out.

Rosemary lost all hope at this point. Her substance abuse increased, and she went back to working the streets to support her habit. Five years later, at the age of 28, she is HIV-positive, still on the streets here in Ottawa, has no top teeth, is covered in physical scars, and we can only imagine the extent of the mental and emotional wounds.

As a direct result of policies of residential schooling, followed by those of the children's aid, no members of Rosemary's family have been raised at home by their own parents for at least six generations. This is a mental health problem.

I want to talk about mental health and addictions in an urban, indigenous context. No other population group in Canada's history has endured such a deliberate, comprehensive and prolonged assault on the family and on their human rights.

We have to ask, when a parent has an addiction, do they lose the human right to raise their child? Because that's what's happening in our communities. Yet many Canadians, including those in the human service sector, remain unaware of the full scope of these injustices or their impacts. In fact, the question we hear most often is, "Why can't you just get over it and move on?"

Marlene Brant Castellano talks about colonization in a way that helps answer that question. She says, "Confidence in the ethical order of the universe is instilled by experience in the family and reinforced by the larger community, by ceremonies that generate shared awareness, and by language, the signs and symbols by which we define and share our perceptions of reality. This concept of an ethical universe stabilized by family, community, ceremony, and language is not unique to aboriginal society. What is distinctive about our experience as aboriginal peoples is the history of having each of those stabilizers systematically undermined by the colonial experience, leaving individuals isolated and vulnerable in a universe that appears chaotic and is definitely threatening."

Not all survivors of residential schooling or their descendants struggle with mental health problems or addictions. In fact, many are a living testament to the resilience and the beauty of the human spirit. Their unshakable determination to heal themselves, their families and their communities and to revitalize language and culture is an inspiration.

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Even so, study after study consistently links disproportionately higher rates of addiction and mental health problems with the intergenerational trauma that is unique to the experience of indigenous people in this country. The response from our social institutions is at best a persistent, systemic indifference and is at worst, judgmental and punitive, blaming those with addictions for poor lifestyle choices, attitude problems, character deficiencies, being hard to serve or resistant to treatment. Our people are often re-victimized instead of helped in the process of going to health centres, especially around addictions and mental health. I can answer questions about that further in terms of some of the methods that are used to calm people.

Services run by and for indigenous communities, however, are grounded in the belief that history and culture matter profoundly; that the health of individuals, families and communities is inextricably connected; and that well-being throughout the lifespan, from birth to old age, has four interrelated aspects: the mental, emotional, physical and spiritual.

Minwaashin Lodge is a community-based service run by and for Inuit, Metis and First Nation women. It provides prevention and intervention services for grandmothers, women, infants, children and youth who are survivors of family violence and the residential school system, including intergenerational impacts. It has been operating for over 15 years, and it has grown to serve over 1,500 clients annually. I've included a list to show you the extent and scope of the services provided. The 19-bed emergency shelter is always full. The addictions recovery and support programs are active; 80% of those—it doesn't say here—are involved with the children's aid. There are also other programs, including housing outreach, employment preparation and professional education about cultural issues.

It's important to know that we do things very differently. I'm really hoping the committee understands this, because we cannot be—other mainstream programs receive money and say they serve aboriginal people. Sometimes they stick a feather on a program or they'll hire an indigenous worker, sometimes as a receptionist, and say that they're handling the problem, but we do things very, very differently in terms of our services.

In an indigenous worldview, healing is a lifelong process of restoring physical, mental, emotional and spiritual balance. Community-based services run by and for indigenous people provide a unique opportunity to be with others on the same healing journey; to learn the beauty, wisdom and vitality of traditional cultural teachings and practices; and to experience cultural safety. And that means a safe environment in which to speak the truth of one's experience without being misunderstood, pitied, misjudged, blamed or punished.

Such services identify and directly address the underlying causes of addictions and mental health problems unique to the historical experiences of indigenous people. They provide an opportunity to reconnect with and

maintain culture and a pride-based, versus a shame-based, cultural identity. They model and foster healthy relational attachments to staff, family members, kin and community.

There's a chart at the end of this report that depicts the life-cycle service model. Services and ceremonies are provided along a continuum from infancy to old age. For newborns, there are welcoming and naming ceremonies; for toddlers, there are walking-out ceremonies; for youth, vision quests and opportunities to challenge and lead; for the community, there are feasts, powwows, assemblies and seasonal celebrations; for elders, there is the opportunity to transfer cultural knowledge and wisdom to the next generation.

One of the critical gaps in services is for dual-disordered women—women with mental health and addiction problems. Minwaashin undertook a study last year to look at the feasibility—because so many of the problems seem to be centred around children's aid and child protection—of a treatment centre for women and their children, a long-term residential treatment facility. We walked to 31 stakeholders, including people from the Royal Ottawa Hospital, from the police department, from the children's aid, and every one of them was very, very enthusiastic and supportive about the need for such a treatment centre.

I have some quotes there. I'm not going to go over them. I'm just going to say that all of these quotes are from non-aboriginal, front-line service providers—some mental health psychiatric outreach nurses, some from police—and they talk about the incredible level of violence that indigenous women face in the streets of Ottawa. We know that many women who end up in the streets—aboriginal women—are murdered or missing. They talked about how, if we can get at the problems before they become hard-core, we have a much better chance of improving our outcomes.

In the five years since Rosemary returned to the streets, much has been achieved in Ottawa and in the province. The children's aid society and Ottawa police have taken concrete steps to improve their services and the way they respond to indigenous people in crisis. Services run by and for indigenous people have increased and expanded, and opportunities for respectful inter-cultural collaboration and service coordination are being sought more frequently.

Provincially, the aboriginal healing and wellness strategy has done a great job in developing a holistic framework for health and healing. Changes to the child protection act were very important and are being implemented, now requiring a differential response and alternative planning and decision-making for indigenous children. Yet there is still no comprehensive, coordinated provincial strategy capable of addressing the mental health and addiction problems of indigenous people.

We know what needs to be done. Most urgently, we need culture-based outreach services for pregnant women with addiction and mental health problems, and we need long-term dual disorder treatment centres where they can

recover in a supportive environment without the added stress and fear of losing their children. We need relapse support, aftercare and long-term follow-up run by and for our communities.

Another urgent need is for youth engagement and peer-led prevention services by and for Inuit, Metis and First Nation youth. We need to reach them much, much earlier. In that context, we crucially need education systems from kindergarten to university to tell a different story about indigenous people and history so our youth can engage in a positive, healthy way with their learning environment. We need equality of access to housing, employment and resources. It isn't in the report, but we need cultural competency in the mainstream. We need to do much better on this. Most providers only see our community and our people at their worst and have no idea of what we have to offer in terms of mental health and healing—and we have a great deal to offer.

Rosemary's story illuminates the unique complexity of mental health and addictions in an indigenous context. It's a story rife with missed opportunities. According to Thomas King, "The truth about stories is that that's all we are." Rosemary's story is Canada's story. This is our collective truth. If that story is to change, we all need to think, plan and act differently, and we need to do it before yet another generation is impacted by the dismal failures of our past.

I noted previously that no other population group in Canada's history has endured such a deliberate, comprehensive and prolonged assault on their families and their human rights. We see clearly the outcomes of this assault in Rosemary's story. In order to succeed, efforts to correct these outcomes must be equally deliberate, comprehensive and prolonged.

In the words of Buffy Ste. Marie, "We are faced with insurmountable opportunities."

Miigwech, marsee, qujannamiik.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Deborah. We probably have time for one question. We'll go to Christine or Sylvia.

Ms. Sylvia Jones: I'm going to go to the practical: You presented this feasibility study in July 2008?

Ms. Deborah Chansonneuve: We produced the report, yes, in July 2008 and now we're looking at trying to get funding to have a business plan.

Ms. Sylvia Jones: Have you presented it to the provincial ministry, the feds? Where has it gone since then?

Ms. Deborah Chansonneuve: We presented it at a national policy conference. I don't know how many places it has gone, to be honest.

The Chair (Mr. Kevin Daniel Flynn): A short one, France.

M^{me} France Gélinas: We don't have that. I come from northern Ontario and I would love to have one of those. We don't have one either. Is this to serve all of Ontario, or Ottawa only?

Ms. Deborah Chansonneuve: This is would be to serve eastern Ontario.

M^{me} France Gélinas: Okay.

Ms. Sylvia Jones: Sorry, I should have asked—can I go back?

The Chair (Mr. Kevin Daniel Flynn): Go ahead.

Ms. Sylvia Jones: Without me scanning it all, what's the dollar value of setting up this treatment centre?

Ms. Deborah Chansonneuve: We haven't done the business plan yet, but we're looking at probably in the area of \$1.5 million to \$2 million a year.

M^{me} France Gélinas: How big is the First Nation, Metis, Inuit population in your catchment area and how many First Nation communities do you have? Sorry; I don't know this area that well.

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Ms. Deborah Chansonneuve: There are 10 First Nation communities within a two-hour drive of Ottawa. There's a very high rate of migration between those communities and the city. At any given time, it's very hard to say. We have the largest Inuit population of any city in Canada, in an urban context: There are around 1,500 people in this city. We estimate that there are between 25,000 and 30,000 indigenous people in the area.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today, Deborah. Great presentation.

Ms. Deborah Chansonneuve: Thank you very much.

JOYCE McNEELY

The Chair (Mr. Kevin Daniel Flynn): Our 3 o'clock appointment is Joyce McNeely. Joyce, if you'd like to come forward.

Interjection.

The Chair (Mr. Kevin Daniel Flynn): I think this is it.

Ms. Joyce McNeely: I'll try this one. Although I don't really need a microphone; I can do this without a microphone.

The Chair (Mr. Kevin Daniel Flynn): Well, you know what, that seems to have been the bad one. Why don't you try the middle one? That's the only one that hasn't gone funny.

Ms. Joyce McNeely: Eeny meeny miney moe?

The Chair (Mr. Kevin Daniel Flynn): Although it's working now, so maybe you should stay there.

Ms. Joyce McNeely: Because I'm sitting a little further back, I think.

The Chair (Mr. Kevin Daniel Flynn): Yes, you'll sit down and it won't work. I know it.

Ms. Joyce McNeely: Okay, we'll see how it goes.

The Chair (Mr. Kevin Daniel Flynn): We're all yours for 15 minutes.

Ms. Joyce McNeely: Oh, good. Well, I'm going to try and do this in 15 minutes. I know the microphone will get turned off and I'll be kicked out otherwise, but anyhow.

My name is Joyce McNeely. I'm 48 years old and I am living presently with concurrent disorders. I'm an alcoholic in recovery. I've been in the continuum of

recovery now for seven years, and I say "the continuum" because I had a relapse 16 months ago. I'm bipolar, medicated—yes, I took my medication today. That's a joke. You can laugh. And I have post-traumatic stress disorder, which I've been living with for a very long time. I suffered severe and multiple abuses as a child at the hands of my mother and many of her boyfriends. I knew neglect; I knew hunger; I knew poverty, intimately. Unfortunately, time and circumstance have rendered me back into the hands of poverty. I'm trying to live, not very successfully, on CPP disability.

I'm kind of curious as to where I fit in, because technically I'm considered disabled; but I'm very much an invisible disabled person because, for all intents and purposes, I look perfectly healthy and I can do this today. Today I can do this: I can sit here and I've managed to get everything in order to present to you my story. It's simply my story.

I would like to share with you my daughter. She is 11 years old, and I will try not to break down. I realized very quickly that I was not going to be able to care for her full time, and I left her in the care of her father here in Ottawa. She is thriving. It was the most difficult decision I ever made but it was the best decision that I made for her. I see her regularly, spend time with her regularly, unsupervised. I am not a threat to her in any way; I am more a threat to myself than anyone else, quite frankly. That's indicated by my excessive abuse of my body through my teens and twenties and now, finally, ultimately only seven years ago, coming into recovery for alcoholism.

I tried to commit suicide when I was 14. My mother abandoned me at the Royal Ottawa Hospital and I resided there for six months until my foster mother rescued me. I lived with her for three years and I still have an ongoing relationship with her. She's still in my life and she was actually in the delivery room when my daughter was born. Carol has supported me unconditionally, accepted me unconditionally, loved me and forgiven me unconditionally. Those are the things that I have needed in order to grow.

I can tell you what I understand about my disease, and I would like to share with you what I understand are the technicalities of it. I'm well-educated as far as self-educated is concerned. There were several books that I read in trying to understand my illness and my brain: Daniel Goleman, I believe is his name, wrote *Emotional Intelligence*, and he spoke about the very early experiences of a child and that those experiences are imprinted indelibly on the centre part of the brain. I believe it's called the hippocampus, and—I may be wrong—the technical parts of it. The brain develops around that and everything subsequently either reinforces—it depends; have you had a positive experience or have you had a negative experience?

I can tell you that for the most part the majority of my childhood was a negative experience. I was beaten regularly, humiliated regularly. As an example, after one beating that I was given for trying to look after my

youngest sister, I was black and blue from the middle of my back to the back of my legs, and my mother stood me up in front of my babysitter and her boyfriend and said, "Pull your pants down now so they can see what you got today." Not only was I brutalized but I was humiliated on top of it.

My mother and my siblings have chosen to disown me. Luckily, I have a common-law husband and, coincidentally, he happens to be Inuit. So I have a unique perspective about the Inuit population here in Ottawa and I could tell you a few things about addiction.

My common-law husband and I met in the basement of a church at an Alcoholics Anonymous meeting, so we figured there was nowhere to go but up from there, hopefully. We did. He will celebrate six years of sobriety from alcoholism on September 28. So it can be done. Peer support is the crucial aspect.

I would like to give you some hope. I have e-mailed an abundance of information. I realize that all of you are inundated with paperwork. I'm sure we've done a good job of killing a forest today. Nonetheless, there are a couple of articles that I would hope you would take the time to read. One of them is called *Healing Society, Healing Ourselves*. This is an amazing journey that has evolved into a business in Yonkers, New York. There's a little book that was published. The author of the book is Bernie Glassman. The book is called *Instructions to the Cook: A Zen Master's Lessons in Living a Life That Matters*. It tells us how to heal society and heal ourselves, and peer support is the central component of it. It's also talking about employment, skills training, meditation, which for some people seems a little esoteric, so I will reference Jon Kabat-Zinn's *Mindfulness-Based Stress Reduction*, which I'm sure any of you who have any kind of academic background are familiar with. I'm certain that the Royal Ottawa could tell you all about it.

I have had, to date no significant contact with the psychiatric community for as long as I have been asking for it. I was at Amethyst for two years. They do a wonderful job over there but they had to kick me out because they didn't have enough money to allow me to continue. I could have used ongoing support and help.

The other article that is attached to *Healing Society, Healing Ourselves*—and I apologize if I'm a little scattered. I didn't write anything down. I'm not good at writing anything down and referencing anything from writing. That's why I'm only going to reference what I have here.

The Chair (Mr. Kevin Daniel Flynn): We've been hearing you and you're doing a great job.

Ms. Joyce McNeely: Thank you.

I did reference *Mindfulness-Based Stress Reduction* and I do have information contained in that paperwork with reference to that specific program. I believe they are out of MIT in the United States.

Interruption.

The Chair (Mr. Kevin Daniel Flynn): We hid the wires under there just to fool you.

Ms. Joyce McNeely: Thank you.

Beyond Healing Society, *Healing Ourselves*, there is the Social Venture Network. What they started in Yonkers, New York, was simply going into one of the most difficult areas in New York, where there were the most homeless, the most addicted, the most mentally ill, and they started taking these people off the streets and they gave them a home, with the condition that they would go to whatever meetings were necessary, generally peer support—AA, NA—psychiatric support. If they needed psychiatric care, they would get it. They had a bed, they had food, they had clothing. They were given a job in the bakery; it's called Greyston Bakery. Greyston Bakery evolved from that small, low-tech operation into a high-tech, fully—I believe it's a Fortune 500 company now, this Greyston Foundation. They now provide the brownies and the cookies for Ben and Jerry's ice cream. They've gone beyond just doing social housing. They do health care, they do schooling and they do daycare. I would also suggest that that would be the other bit of information that you need to have: the social venture network connected to the Greyston Foundation.

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I want to leave you with the impression that there's hope. Yes, it's going to require money; there's no doubt. You can't get around it. There's going to have to be money put into something somewhere, but I believe that a peer support network of one kind or another is ideal. I did file an opinion with the housing ministry. The housing ministry is doing housing strategy consultation.

I've also included that in my paperwork because I referenced *Healing Society* and how we can do this here. We can do our own model, and I'd be happy to volunteer to be one of the first to do it. One of the things is that I'm losing my identity here in this city. I know that I have something to contribute. I don't know what my potential is. I heard one psychiatrist talk about curing me of my post-traumatic stress disorder and of all of the other ills that may be affecting me. Quite frankly, this is the way I am. God's will be done. I've survived all of this and I'm here to tell you my story. If I wasn't here to tell you my story, then how are you going to understand how to make the changes that are necessary to help us?

Yes, we are dying out here because there are not enough services. There's not enough housing. There's not enough money. There's not enough of anything. But if we have the will, it can be done. I would like to see something done for my daughter to ensure that I'm around for her. Thank you.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much. You've left about three minutes, and we're starting off this time with France.

M^{me} France Gélinas: Thank you for sharing your story. We have heard quite a bit about peer support, and I'm sure we're going to do something in that direction. The piece that is kind of a novelty so far is that you're the first one to talk about social enterprise. You named one in the States, but there are some in Ontario also. I was curious to see, have you been in touch with social

enterprises here in Ottawa? Are they available? Have you had any exposure to them?

Ms. Joyce McNeely: I am presently dealing with multiple issues related to my former employer, my former union and my former disability carrier, from which I have been trying to get what is mine back. I don't have the energy, I don't have the time and I don't have the resources to be going out to all of these other places. I concentrate on my self-care.

I joked about it, but taking my medication first thing in the morning is really important. I had to get dosettes, because I couldn't remember whether I had taken my pill or not, and that was dangerous because I get depressed and suicidal very quickly without my medication.

This in itself has taken tremendous energy, and up until 12 noon today I really did not know whether I could do this. I had asked some friends to come and support me, and they were unable to come. It took great effort for me to come here. I did break down a little bit, but to not totally break down is an accomplishment for me.

M^{me} France Gélinas: I'm very proud of you.

The Chair (Mr. Kevin Daniel Flynn): Any other questions? Liz, do you have a question?

Mrs. Liz Sandals: Thank you so much for coming and putting all the effort that you have done into sharing your story with us, because it obviously has been a struggle for you to come. But it's really important for us to hear from you at first hand.

I was just wondering, having worked your way through your life, is there one support or one program that we could have had in place for you that would have made a difference and enabled you to be in a recovery mode sooner? What was the biggest missing chunk? Or is that hard to—

Ms. Joyce McNeely: The biggest missing chunk was when the children's aid investigated my mother on several occasions and I was never taken from that home. That was the first and the meanest strike against me. Then it just kept building up.

Mrs. Liz Sandals: So just going right back to that childhood experience and not having the intervention that needed to take place.

Ms. Joyce McNeely: Yes. And I've heard and seen things about children—and I will be the first to say that if there is anyone involved in addiction, who's active in addition, then a child should not be in that environment, period. I'm witness to that.

The fact of the matter is that I have an article here on post-traumatic stress disorder; they talk about the ratio of this incident versus the chance that they're going to develop post-traumatic stress disorder. Out of eight or nine of the violent offences, I have six or seven of them, so it's no wonder that I've developed post-traumatic stress disorder. The miracle is that I'm sitting here and I'm semi-coherent, that I can speak to you and tell you my story. That's the miracle, that my brain has been able to heal well enough to do this. I know I have something to contribute and I do want that opportunity. I want the opportunity to contribute. I want the opportunity to help other people.

I haven't had access to psychiatry. They talk about healing me for post-traumatic stress disorder, but if I don't even have access to psychiatry—if I can't even get a psychiatrist to establish a trust-based relationship with and go into those traumas, how is it ever going to heal? All my medication is doing is just keeping a damper on all of those things. It's no wonder I go depressed and suicidal when I'm off my medication.

Right now, what I need most of all is a change from this urban environment. I am overly sensitized and I don't know—there's agoraphobia, there's sociophobia, there are other phobias that we develop, and that's directly related to the overstimulation of urbanization. We need—I need, and maybe we need—some little community where we can support each other and grow vegetables and spin some wool. It may be mundane, but I did actually learn how to spin wool and I finally learned how to knit. Doing things with my hands is very therapeutic.

There's also some additional information in there about a program where they use horses. It's called Equine Assisted Growth and Learning. It's not an airy-fairy concept. There are many things that we can derive from being connected to nature, and that's another huge missing gap for me.

The Chair (Mr. Kevin Daniel Flynn): Thank you for coming today, Joyce. We really appreciate it.

Ms. Joyce McNeely: Thank you very much.

The Chair (Mr. Kevin Daniel Flynn): Thanks for your time.

Ms. Joyce McNeely: God bless you all.

CHAMPLAIN MENTAL HEALTH NETWORK

RÉSEAU DES SERVICES DE SANTÉ MENTALE DU DISTRICT DE CHAMPLAIN

The Chair (Mr. Kevin Daniel Flynn): Our next speaker this afternoon is from the Champlain Mental Health Network, Marion Wright. If you'd like to come forward? I'm sorry—Renée. You're not Marion. Marion was supposed to be here but you're here in her place.

Ms. Renée Ouimet: Yes. Unfortunately Marion's out of the country, so I've come to replace her as a representative of the Champlain Mental Health Network. I also co-chair a work group of the Champlain Mental Health Network which is quite an exceptional one, because it's called the mental health promotion and education work group, so therefore very much looking at the importance of mental health promotion, primary prevention, education and training, which has not been funded necessarily by governments in the past—some.

1520

The Chair (Mr. Kevin Daniel Flynn): You've got our attention for the next 15 minutes. You can use that any way you like.

Ms. Renée Ouimet: I'll just go through the slides. What I want to do is give you a little bit of background about the Champlain Mental Health Network as well as its priority issues and what it's up to, basically. Thank you for this presentation. Merci beaucoup.

The Champlain Mental Health Network has existed and has been doing continuous planning since 2004. It brings together consumers, families and service providers, and is really looking at organizing a seamless, person-centred mental health system within the Champlain network.

It also includes other members, or cross-membership, like the Réseau des services de santé en français, obviously for French-language services; the addictions world; primary care with regard to family physicians or community health centres; First Nations; children and youth; and now is really working very closely with an organization that I know made a presentation today, the Champlain Addiction Coordinating Body, to amalgamate, to really look at planning the integration of mental health services and addiction services in this region. They have been having several meetings to be able to integrate.

Our work at the network is grounded on diversity, which means many things, including French-language services, services to new Canadians, etc. We're really looking at it in terms of system thinking and very much a recovery focus.

How do I switch slides?

The Chair (Mr. Kevin Daniel Flynn): Do you need some help? I just recruited somebody for you.

Ms. Renée Ouimet: Merci, Alfred.

The Chair (Mr. Kevin Daniel Flynn): He is excellent for this job.

Ms. Renée Ouimet: Yes. He's a good colleague of mine too. Alfred got me here from CAMH.

As I mentioned, we've been planning and going into action, we've set priorities from 2006 to 2016, we've recently looked at the recommendations around the annual report of the Office of the Auditor General of Ontario on community mental health, which is all really helping us in the sense of our planning and priority areas.

Just to mention a couple of initiatives, there is a work group of the network that has been looking at integrated access of all in-patient mental health beds within this community—in other words, no beds belong to one particular organization—but really centralizing access, including the rural areas, and also looking at discharge and transition from hospital with regard to people with mental illness as well as developmental disabilities.

We've also been working on language and our target populations with the addiction systems. We're looking at clients and consumers. Our target population is people who experience or are at risk of mental health issues as well as problematic substance use, including gambling, and also very much a focus on how families can be integrated in the system.

Just to look at a few of our goals—they're far-reaching. The first one, really, is looking at the implementation of coordinated access to the continuum of mental health

care and addiction services with linkages to allied services—for instance, primary care—to meet the diverse needs of our target population in Champlain. Examples of that: We're looking at developing a navigation function—coordinated access to ensure that people get referred to the correct service; access to services closer to home—we have issues, for instance, of transportation in rural areas, for seniors and for other people; flexible hours—some of us are offering services after hours, and that needs to be looked at specifically, especially with people with mental health issues who are working.

Increased community support workers: we need many more in this region and for the gamut of continuum of care, from prevention to recovery to maintenance. An example of this is that we know that we need many more community mental health and intensive support in the Ottawa region. We know that if we had this, this would decrease costly emergency room presentations, inappropriate admissions, delayed discharge etc.

Our next priority is meaningful engagement of clients and families, and I think we have been very much trying to do that within the network, in the sense of engaging clients and families in service development, implementation, evaluation in our networks, system change and service provision. But we really need to continue education and training with regard to service deliveries, in the sense of including consumers and families within service delivery in our region. For instance, I think we need to continue education of service providers, peer support and self-help groups etc., which is still lacking.

Another priority is determinants of health. We definitely have issues with income levels in Ottawa and many people with mental illness who are still living in poverty. Issues like ODSP levels; maybe to look at employment with support, access to employment etc. We still have an inadequate housing stock in this region as well as support to that housing stock.

I think I want to put a little bit of an emphasis as well on that as an opportunity for many people with mental illness who wish to work and have difficulty finding work. We need to do some education with employers with regard to accommodation for people with mental illness. We know that over 90% of people who have severe mental illness are unemployed, and many would like to be employed.

Next one: prevention and early intervention. I think we've tended to emphasize early intervention with regard to mental health issues and addictions in the past. I think we really need to look at prevention of mental illness in children and youth. We know that many programs exist in this area in the sense of mental health promotion and resilience-building that we could have in schools, but we have no funding, and no funding to research it either. So, a definite need there.

Capacity-building: ensuring that the right people are in the right place at the right time, and I think the lady before has really been talking about that. We need the competencies, interventions and capacity to respond to client needs, and the inclusion of health providers, peers,

families and the broader community. We need to build and enhance the capacity and appropriate financial resources to provide those services. We have them, but we need many more along the continuum, in both official languages. We also need to increase the treatment services' availability as well. We are working very hard on standards of practice, performance indicators and accountability within this region.

Human resources capacity development needs to be looked at: education and training in both the mental health and addiction sectors.

To summarize, I think that the Champlain Mental Health Network has been working very hard—and working in both the mental health and addiction systems—to really look at an integrated model of services for people with mental illness and substance issues. Of course, we need to continue working on the development of services that are evidence-based and efficient. We need to continue working with our LHIN, which we are, at looking at outcomes. We are very prepared to continue with these responsibilities but are very aware that we still need dollar investments to be able to really have the efficient system that we need in Champlain.

1530

The Chair (Mr. Kevin Daniel Flynn): Thank you, Renée. You've left us a little bit of time for questions, starting with this side of the table. Liz?

Mrs. Liz Sandals: I'm just curious: First of all, who belongs to the mental health network? Is it all the service providers for both children and adults?

Ms. Renée Ouimet: The children are represented, but it's mostly the adults, as well as the addiction services. There are over 200 agencies that are represented in the Champlain network. But also, there is a council of the network that meets on a monthly basis and has representatives of different sectors like—

Mrs. Liz Sandals: So if you've got all those agencies, then, if I were a mental health patient or a family physician who was trying to connect me with the appropriate one of those 200 services, I'm guessing some are in the community, some are more accredited services, so there's a huge range. How would I get connected to the right one of these 200 services if I lived in Champlain?

Ms. Renée Ouimet: That's one of the things that we're working on—central access—because it is difficult right now. It's difficult for consumers; it's difficult for families, in a sense, to access—we're working on a central access; we don't have one.

Mrs. Liz Sandals: So at this point, there isn't?

Ms. Renée Ouimet: No. If you use ConnexOntario, there are certain things that you can use, but that's what we need. That's what we're working on.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Renée. Sorry. Christine and Sylvia? I'm sure you'll answer it eventually. Sylvia?

Ms. Sylvia Jones: Thank you for stepping in today, Renée. I wanted to talk about your priority of capacity-building and see if the network had made any comments or would like to share with the committee the decision

that's coming forward on the closure of the Brockville psychiatric facility, because that will obviously affect capacity.

Ms. Renée Ouimet: I think that it is being discussed in the sense of how that can be done with regard to the Royal Ottawa Mental Health Centre as well as community agencies. I know there has been discussion, but I don't know otherwise.

Ms. Sylvia Jones: So you see it as an issue coming forward if the—

Ms. Renée Ouimet: Oh, sure. Absolutely. And it is being discussed.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Sylvia. France?

M^{me} France Gélinas: J'aimerais, dans ta priorité—toute la priorité de prévention et d'intervention. Est-ce que vous avez des exemples de programmes qui parlent de prévention primaire qui fonctionnent bien à Ottawa ou dans la région que vous desservez?

M^{me} Renée Ouimet: Je sais qu'il y en a plusieurs. Je peux vous donner un exemple d'un programme qui s'appelle Parlons de la maladie mentale. C'est un programme qui a été développé par l'Association canadienne pour la santé mentale, Ontario, CAMH et Mood Disorders. C'est un programme qui a été développé en partie pour que les enseignants l'offrent en plus pour des personnes qui ont une maladie mentale qui se présentent en classe en 11^e et 12^e année pour présenter leur maladie et parler de leur rétablissement, en plus de parler de services disponibles pour les jeunes.

Alors, c'est un exemple dans le sens que c'est un programme qui contre les préjugés nettement. Cela a été évalué à augmenter les connaissances des jeunes à contrer les préjugés à l'école et aussi l'identification précoce. C'est un programme qui est utilisé, par exemple, à Champlain et dans d'autres régions de l'Ontario, mais il n'est pas subventionné. Il y a énormément de difficulté à trouver des sous—un petit peu de Centraide. Il y a même des organismes qui font des levées de fonds pour essayer de le faire fonctionner. Ce n'est pas évident. C'est un exemple, mais il y a plusieurs exemples aussi de programmes qui ont été développés pour les enfants et les jeunes sur les résiliences, par exemple, la communication, la résolution de conflits, etc., qui ne sont pas subventionnés non plus. Puis encore, ça prend des outils aux jeunes pour pouvoir prévenir—n'est-ce pas?—les maladies mentales, ou au moins transiger avec leur maladie mentale si c'est biochimique.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today.

Ms. Renée Ouimet: You're welcome.

ONTARIO COLLEGE COUNSELLORS
CONSEILLERS ET CONSEILLÈRES
DES COLLÈGES D'ARTS APPLIQUÉS
ET DE TECHNOLOGIE DE L'ONTARIO

The Chair (Mr. Kevin Daniel Flynn): Our next presenter today is Michel Lefebvre, La Cité collégiale.

You've got a printed presentation. Thank you. There should be some clean glasses and water, if you need any. Make yourself comfortable. Everybody's getting 15 minutes today. You can use that any way you like.

Mr. Michel Lefebvre: Thank you.

The Chair (Mr. Kevin Daniel Flynn): If you want to save us a little bit of time at the end for some questions or discussion, that would be great.

Mr. Michel Lefebvre: Good afternoon, Mr. Chair and members of the panel, my name is Michel Lefebvre. I'm a college counsellor and member of the Ontario College Counsellors. The OCC is in its 42nd year as a provincial and bilingual association dedicated to enhancing the quality of the counselling profession in Ontario's colleges.

In fulfilling its mandate, the OCC promotes policies and practices for the provision of accessible, competent, and accountable counselling services throughout the college experience in the human lifespan in a manner sensitive to the pluralistic nature of our society.

I guess I'm going to read this. I only had a chance to read my presentation a few times. This afternoon it took me 13 minutes. Anyway, I'm going to read pretty rapidly and if you have any questions at the end—but I want to make it so you can fully understand it.

The Chair (Mr. Kevin Daniel Flynn): Do it any way you like.

Mr. Michel Lefebvre: Thank you.

Ontario College Counsellors supports the objectives of the Regulated Health Professions Act, namely to protect the public from harm, to promote high-quality care, and to treat individual patients/clients and health professionals in an equitable manner.

Our standards of practice, statement of ethics and all our services are dedicated to using our counselling competencies to meet educational, career and the personal, social and psychological needs of our college community.

OCC currently has 160 members and serves thousands of clients in 24 community colleges. Our members practise under the title of college counsellor and they provide a wide range of mental health services.

OCC members regularly address a wide variety of mental health concerns, a wide variety of clients from diverse backgrounds and a variety of ages, from adolescents with behaviour problems through to seniors with issues related to aging and depression.

At present, as you are aware, the counselling profession in Canada is not regulated by a statutory process except in the provinces of Quebec and Nova Scotia. OCC believes that college counsellors will qualify to come under the auspices of the Ontario 2007 Psychotherapy Act, and will register with the title of registered psychotherapist or registered mental health therapist.

Ontario college counsellors are highly qualified and work with a significant and growing population of students presenting with severe mental health issues.

OCC est le comité représentant de tous les conseillers et conseillères des collèges d'arts appliqués et de tech-

nologie en Ontario. Notre organisme est responsable devant le conseil des présidents par l'intermédiaire du comité des collèges des services aux étudiants.

OCC est un organisme professionnel dont l'origine remonte à la création du réseau des collèges d'arts appliqués et de technologie en Ontario. Il a toujours eu pour objet de promouvoir des normes élevées d'éthique et de pratique dans les services de counselling des collèges, de contribuer au perfectionnement professionnel de ses membres et de faciliter les relations de travail efficaces parmi ses membres et entre les services de counselling des collèges et d'autres organismes.

OCC is proud of its efforts, which aim to protect the public interest and to ensure its members deliver excellence in their standards of service. It is from this viewpoint that we welcome the opportunity to offer our input to this committee.

We are pleased that the Legislature is taking a comprehensive approach to reviewing how the mental health of Ontario's population can be improved. I can certainly give you a view of mental health needs within the college system.

Improving a society's mental health is about more than simply expanding access to services presently funded by the Ministry of Health. In order to serve our mental health population well, improvements will particularly need to address issues of timeliness, affordability, appropriate lengths of services, choices of therapies and types of therapists, and always quality and effectiveness of services. It is also understood that services delivered solely on too little funding will not adequately address needs.

Individuals with serious and complicated mental health issues, such as severe depression, anxiety or eating disorders, often present first to the counselling department in colleges. The nature of these conditions, especially within the context of attending school, would necessitate timely response and would often require collaborative work with other professionals, some of which cannot be provided only by health and hospital facilities. College counsellors play a vital role in helping clients mitigate the effects of such issues and assist them to learn to cope with their symptoms of distress even as students attend to their school studies or await additional referrals.

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Improvement in access and referral are needed within college counselling centres in order to better service our students, especially those dealing with serious mental health issues. Across all of North America, counselling departments in colleges and universities report seeing a large increase in seriously mentally ill students. Waiting times to see a counsellor are getting longer as more students seek our services; as presenting issues increase in complexity and require longer therapy; and as counsellor positions have not kept pace with the increasing demands. Staffing college counselling services adequately would be very helpful to our ability to respond in time and provide ongoing therapeutic support.

Counsellors are also unable to refer in due time to appropriate services in the broader community due to

lack of accessibility. Improving overall accessibility to all mental health services would serve the student population better.

In the broader community there are too few and too limiting services for our students suffering from mental health issues. Firstly, students have very little money to access practitioners in private practice, whose waiting times are short but whose costs are high. Only a very minute minority of our students may have the financial support of parents for this kind of private care.

For students who must function at their best under the academic rigours of our school programs even as they cope with mental health issues, the time delay to access OHIP-covered psychiatric and other mental health services could lead to unnecessary disruption of their studies. Waiting up to six months to a year to see a psychiatrist is too long when one is still expected to write papers, take exams and make class presentations. Getting behind in one semester may result in delaying school for a whole year.

Even when students do receive community-funded services, the services may limit sessions and prove to be inadequate. Many organizations, due to the lack of funding and infrastructure, can provide no more than six or eight sessions of therapy or counselling.

Those clients who require immediate or more intensive long-term care, for issues such as childhood sexual abuse, can easily fall through the cracks. Whereas brief therapy and one physician visit can be very helpful for uncomplicated issues, each service would fall very short of meeting the needs of clients in serious distress or in chronic crisis.

The short-term model also necessitates the need for highly skilled professionals who are trained in methods of intervention, rather than just simply assessment, to treat these individuals on an ongoing basis and ideally to help them resolve their symptoms so that they may enjoy higher functioning.

As a result of these limitations and the increased number of students entering the community college with severe mental health issues, college counsellors come face to face with students with very serious mental health issues related to high-anxiety situations where they are simply struggling to deal with daily and numerous demands and changing variables: family breakdown situations, health problems, feelings of loneliness from being far away from home, financial problems, depression, suicidal thoughts, loss of interest, loss of friendship, and dealing with an intense environment where they feel lost and alienated.

Sometimes students are just burnt out by their intense new life as a young adult away from home, dealing with their new friends, dealing with their sexual orientation, starting new jobs in a different environment, and learning and studying in a new and demanding environment.

Some people, when they think of college and university students, think of bad-hair days and breakups, when the reality is often that the university or college has to provide a community health clinic where individuals

with severe disorders are treated, many of whom would not be able to afford or access other resources. In addition, many psychiatrists and some psychologists have a great deal of experience diagnosing, but don't necessarily have the resources to provide the ongoing psychotherapy treatment.

Counsellors work with students who are actively suicidal, who have intractable eating disorders, who are dealing with first-episode psychosis, and who are coping with depression, anxiety, illness, the death of a family member, and physical and sexual assault.

One of the benefits of having counsellors who are highly trained is that they also know when referrals to other professionals are needed to enhance the effectiveness of services to students. For example, if a student presents with psychotic symptoms, counsellors are quick to recognize the need to make the appropriate referral to clinics or a medical doctor. While waiting for the referrals to take place, counsellors continue to provide appropriate psychological support.

It's important for Ontario to work to improve access to all mental health professionals. One simple way to greatly enhance the services counsellors can offer would be to be able to refer a client directly to a psychiatrist. You can imagine the frustration when someone waits weeks for an appointment to see a counsellor, then has to wait another period of time to obtain an appointment to see a family doctor—if they have one—and then, yet another wait to be referred to a psychiatrist. Also, this direct referral to psychiatrists would immediately set up the consultative structure needed so that the psychiatrists and counsellors could work collaboratively on behalf of the student referred.

There are shortages in competent and accessible services for mental health in Ontario and there are also inequities or misunderstandings with regard to qualifications that are exacerbating these gaps. Agencies in the system will often only hire counsellors who are registered with a statutory regulated body. Despite the fact that many, if not the majority of, counselling programs across the country have mental health counselling as a major focus, graduates from these programs are often unsuccessful at being hired within medical institutions, such as hospitals and clinics. We have great hope that once the new College of Psychotherapists and Registered Mental Health Therapists of Ontario is functioning, this issue will resolve itself.

The government's action to regulate the practice of psychotherapy through the Psychotherapy Act, 2007, was welcomed by our organization, but we are keen to see the legislation implemented. There is the potential for improving the outcomes in Ontario by better leveraging the full diversity of expertise that is available in the province.

For a mental health strategy to succeed, it is important to recognize that not all people want or need to receive care within the medical model. Our members make an essential contribution to the overall care mix of mental health services available in the province. It is important that a choice of services be available in order to empower

people with mental health problems. There is a need to recognize the role that families and other non-professional caregivers play in the lives of people with mental health problems and to promote well-being among family members and reduce the burden for caregivers. An integrated approach is needed to provide effective support for people with co-occurring mental and substance use disorders. In the transition from child to adult mental health services, youth often fall through the cracks as there is no specific system of care available for this age group.

Because of the diverse skill set of counsellors, they are able to provide counselling to adolescents, adults, couples, families and groups. Workplace stress, financial difficulties and similar kinds of problems, which often lead to depression, anxiety and contribute to family conflicts, are services readily available to people. Working with people affected by mental health, addictions, chronic illness, death and dying are examples of areas in which counsellors work. Many counsellors work with perpetrators of domestic violence, as well as people affected by abuse. A diversity of practice models both complement and take pressure off the OHIP system.

We were pleased to learn that the new amendments to the Psychotherapy Act, 2007, limit the exclusive use of the title "registered psychotherapist" to those who will be licensed by the new college. This is a positive step in terms of promoting clarity to the public and enhancing public protection. Title protection helps the public understand that anyone holding themselves out to be a registered psychotherapist is regulated by the College of Psychotherapists and Registered Mental Health Therapists of Ontario. It is clear to the public that they are accessing care that adheres to a common standard of training and regulation. It is also clear that they can turn to the college for redress in the case of complaint.

The creation of the new College of Psychotherapists and Registered Mental Health Therapists of Ontario offers Ontario a prime opportunity to enhance the quality and scope of mental health services in the province. OCC, Ontario College Counsellors, in collaboration with the Ontario Coalition of Mental Health Professionals, looks forward to working with the Ontario government to bring the new college to life in a way that dramatically benefits Ontario's patients.

OCC is very grateful to have this opportunity to present our views to this committee on behalf of the Ontario College Counsellors. Thank you very much.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Michel. You've used up all your time, but you used it well. Thank you very much for coming today.

Mr. Michel Lefebvre: Thank you.

1550

FETAL ALCOHOL SPECTRUM DISORDER COALITION OF OTTAWA

The Chair (Mr. Kevin Daniel Flynn): Our 3:45 appointment is the FASD Coalition of Ottawa. Diana Fox

and Elspeth Ross, if you'd like to come forward and make yourselves comfortable.

Ms. Diana Fox: Good afternoon.

The Chair (Mr. Kevin Daniel Flynn): Good afternoon. You've got 15 minutes, like everybody else. You've probably heard the whole spiel.

Ms. Diana Fox: Perfect. My name is Diana. I'll start by just giving you a bit of background information. I do apologize. We have been very busy. Today is International FASD Awareness Day. As we've been involved in many activities today, I scanned the e-mail that a colleague sent for me to be here today and didn't make enough copies for you, so I do apologize. I've made it up by putting lots of extra information in the handout for you, so hopefully you will scan and read as you feel fit.

Today is international fetal alcohol spectrum disorder day, and it is a day to raise awareness around the disorder. Fetal alcohol spectrum disorder is caused by a woman drinking during pregnancy and the alcohol effects on the developing fetus. There are a number of disabilities associated with it, both primary and secondary disabilities. The primary disabilities would be sensory integration issues, learning disabilities and cognitive functioning.

The secondary disabilities actually are trouble with the law—I'll just go through some of them here. In a Canadian study, of the secondary disabilities of 92% of individuals affected by FASD, 65% had attention deficit hyperactivity disorder; 45% of the individuals suffered from depression; 21% suffered from anxiety, panic disorder, PTSD, OCD, ODD and bipolar; 92% were rated as vulnerable to manipulation; 82% were victims of violence; and 77% were exposed to physical and sexual abuse.

As a counsellor in trauma and as an addictions counsellor, certainly when we work with individuals with fetal alcohol spectrum disorder, which is both a visible as well as an invisible disability—some of the individuals with fetal alcohol syndrome that we're a little more aware of are more visible when we see them. We can recognize there's a disability and we often accommodate—hopefully we accommodate. But certainly partial fetal alcohol syndrome and alcohol-related neurodevelopmental disorder—that's the invisible disability and we often don't accommodate these individuals. As we heard from many of the speakers this morning at our event, they don't want to let others know that they have a disability because everyone wants to be perceived as being normal, to fit in.

I think today what I would like to stress is more the prevention effort, and Elspeth will talk further about the intervention. But we do need to raise awareness and training. One of the things that I have been doing is training front-line professionals around the disorder and looking at accommodation and interventions that are most effective, both for women who are at risk of drinking during pregnancy as well as individuals who are living with the disability.

One of the things I have noticed across the country as I've done training is that we do not address this issue in

addiction centres for fear of stigma, for fear of driving women deeper into silence. But as we deal with the stigma, as we raise awareness, hopefully we can start talking about the disability and support people who are living with it.

I'll just pass to my colleague.

Ms. Elspeth Ross: My name is Elspeth Ross. I'm a member of the FASD Coalition of Ottawa. I co-facilitate an FASD group at the Children's Hospital; it's where we meet. It's a support and education group. I've been doing it for 10 years and we operate without funding. I do it with a psychologist.

I'm a member of FASD Stakeholders for Ontario. It's a provincial group. I'm on their intervention and support group. We're finalizing three consultant reports on FASD effective practices, one on FASD in schools and the third on respite services.

I'm a parent, with my husband, who is here today, of two young men affected by FASD and we're now parenting full-time our grandson, who is aged 11—not fetal alcohol affected but a victim of trauma and family violence. I work as an educator in FASD and adoption permanency, and I provide an FASD current awareness service by e-mail.

Our boys are both fetal-alcohol-affected—they're 27 and 29—and in many ways, are a success story. By the way, we live in Prescott-Russell, and I see my MPP, Mr. Lalonde, present here today. Both of my boys have graduated from high school and one has graduated from college, in aboriginal studies. They both work seasonally. They live in our lower house. Having a second house is a very good way to cope with family members with fetal alcohol syndrome, but not everyone has one.

My older son has done very, very well, but when there were recent troubles in his life where he had depression, anxiety and panic attacks. He does not have sufficient resiliency to cope with the challenges of life. My younger one had a psychiatrist from a very young age, until age 22, for obsessive-compulsive disorders and now has an addiction counsellor for alcohol.

Our grandson only lasted six days, when he arrived in our family three and three quarter years ago, in school before being excluded—not suspended, not expelled, but excluded. You're only entitled by law to five hours per week with a teacher, if a teacher will take you, but we advocated for 10, got work placement, and he has been in school a year and a half out of almost four years. He just started his second section 23 placement yesterday. We're hopeful.

Not everyone can provide the external brain support that we do for our family. Not everyone can keep the records, remind them, take them to the doctor—I'm talking about adults—and manage money for them.

What do we need? We know about the co-occurrence between fetal alcohol syndrome and mental health and addictions. We know from Dr. Streissguth's research that over 90% of people affected by fetal alcohol spectrum disorder have mental health problems; 60% of children have ADHD—I believe it's higher than that—and 30% have alcohol and drug problems. There was Canadian

research done recently, in 2003, by Erica Clark—and by the way, I've provided you with a bibliography of these items so that somebody, I hope, can get hold of them. Unfortunately, her research found mental health diagnoses in 92% of those she studied, most with ADHD, depression, panic disorders, and 61% with destructive school experiences—it's probably often higher—and high co-morbidity with alcohol misuse.

Look at it the other way. What about the co-occurrence of FASD in individuals with mental health problems and addictions? Underneath the mental health and addictions is the FASD. Often people who are affected by fetal alcohol syndrome don't know that they are affected. It's not an easy thing to admit that you have a neurodevelopmental disorder or disability. They may not know that their birth mother drank alcohol early in pregnancy. FASD is often undiagnosed. It's an invisible disability. The people are not small. They're tall, good-looking, with no distinctive face, are very good talkers, and most are of average intelligence.

As an information professional, I monitor the news, I monitor reports, I do word searches. I know where FASD is not included. FASD is not included in your select committee's discussion paper *Every Door is the Right Door*. It is not included in the documents from the Mental Health Commission. It is not included, necessarily, in concurrent disorders or mental health or addictions symposiums, conferences, workshops and publications. It is not even really considered a disability. It crosses boundaries into many disciplines, from early childhood education to corrections—and what we're working for is to keep people out of corrections. My son has only spent one night in jail. After one night in jail, he came home and said, "Jail is horrible." I said, "Oh, good. I'm glad you feel that way."

FASD is a lifelong condition. The secondary disabilities are variable and can be minimized. Minimized with what? With early diagnosis, structure and supervision, tailored programming and adjusted expectations. There is hope that FASD-affected individuals can maximize their potentials. We need to build on strengths.

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What do we need? The stakeholders for Ontario asked parents. They said our biggest needs are in schools, school programs, and respite. We need respite desperately.

What do we need? An Ontario provincial strategy for FASD. The recent infertility and adoption panel asked for that, and we echo it.

We need FASD included in concurrent disorder strategies.

We need collaboration—other people, of course, have mentioned this—collaboration between ministries and with stakeholders. We need prevention campaigns; Diana talked about prevention. We need education and training about FASD for professionals.

We need an attitude change—people are not wilfully badly behaved; it's a brain disorder—support and understanding.

Basically, all that we really need is services. We need diagnostic services across the province, including distance availability. We need professionals—psychiatrists, psychologists, therapists, counsellors, addiction counsellors—who know FASD, who think FASD. We need special education, and not just inclusive classrooms; we need special programs as well. We need assisted employment, assisted job search, job coach, disability pensions, disability tax credits, a big variety. We need assisted living options, and we need respite care for families, respite care including babysitting.

There is hope. Things are looking up in Ontario right now. It's a very good time for this committee to be doing these things, because you can draw attention to FASD and where it's included in mental health and addictions so that we can maybe bring together to find solutions for Ontario. And this is FASD Awareness Day, so it's a day for us to be speaking to you about it.

The Chair (Mr. Kevin Daniel Flynn): Thank you. I was just reading about the diagnosis for FASD. I'm wondering—it's not a blood test, it's a series of tests, and it's an opinion, I guess?

Ms. Diana Fox: No. They actually have very stringent diagnostic guidelines, so geneticists, actually, and pediatricians diagnose with a team.

The Chair (Mr. Kevin Daniel Flynn): Okay. I was just cruising through them as you were talking.

Ms. Diana Fox: But no, it is not a blood test, and it is quite a lengthy process.

The Chair (Mr. Kevin Daniel Flynn): Okay. The first question, then, is from France.

M^{me} France Gélinas: Thank you. Well, that was a good entry into—I come from northern Ontario. The availability of specialists to diagnose FASD is horrendous. There are no teams willing to give a diagnosis. So how is there in Ottawa?

Ms. Diana Fox: That's a very difficult question to answer. CHEO does diagnose; the geneticists do diagnose both children and adults, so the waiting list depends on the time and the rush. It is a lengthy process. I do know some people, particularly youth and adults, who, because of the length of diagnosis and the amount of time and appointments they need to go to, will abort the process.

M^{me} France Gélinas: We all know that if we treat those children early, they do so much better. In the north, we're not having any successes whatsoever in getting our kids diagnosed early. Are you guys having any success?

Ms. Diana Fox: There certainly is a difference between the north and the south and urban and rural that—I mean, we can't say. We do certainly have better access to services, but I think, as Elspeth mentioned, there is a stigma attached to the disability and many people don't want to think of that as a possibility.

M^{me} France Gélinas: So the kids are still not diagnosed early and they don't get the support they need?

Ms. Elspeth Ross: One of the big problems is lack of knowledge about birth-mother drinking. This can prevent a firm diagnosis. So what we would really like is for

mental health people, doctors, to ask women about their drinking and for people to keep records, for all agencies to keep records, because it's very difficult to get a diagnosis without that information.

The Chair (Mr. Kevin Daniel Flynn): Thank you. Anybody from this side? Jean-Marc.

Mr. Jean-Marc Lalonde: Thank you very much for being here this afternoon. I think it was very important, the presentation that you made, because I was visiting schools just last week, high schools especially, and the problems that we have in high schools at the present time start off really earlier, at grade 6, I guess.

You referred to special programs. I do believe strongly now, after listening to you, that in my next visit to a high school I'll be talking to the principal of the school, that we should have people—like in your case here, the FASD—talking to the girls down there. It's very important that they be made aware, really, of what could come from having some difficulties at one time or another. But I really appreciate the time that you spent to make this presentation today.

The Chair (Mr. Kevin Daniel Flynn): Thank you for coming. Your time is really appreciated. And we did hear from your group yesterday in Toronto as well.

Ms. Diana Fox: Wonderful. Great.

The Chair (Mr. Kevin Daniel Flynn): So we're hearing from you all over the province.

Ms. Diana Fox: Thank you very much.

CATHERINE DUBOIS

GERMAIN DUBOIS

The Chair (Mr. Kevin Daniel Flynn): Our next speakers today are Germain Dubois and Catherine Dubois, if they'd come forward. Make yourselves comfortable. There's some water there if you need it. You've got 15 minutes, like every other group today. You can use that any way you see fit. If there's the opportunity to leave some time at the end for some questions, we'll see if we can share it around the group here.

Ms. Catherine Dubois: Thank you. I'm Catherine and this is Germain. Usually when family members talk about their children, they start with the day they were born, so we promise you we won't do that. I thank you for this opportunity to speak to you.

We are parents of an adult child who suffers concurrent disorders. We are also new graduates of an education program given by Horizons Renaissance, in partnership with Maison Fraternité and Montfort Hospital here in Ottawa. We attended a 12-week course to learn about illness, addiction and all the related information that would help us, as parents, to understand and support our son.

Our son is also a new graduate of the homeless community. He is now housed in a small apartment here in Ottawa provided through Ottawa Community Housing. He had been on the streets for over three years. Throughout these years we experienced, as his parents, a very

solitary struggle as we tried to keep the lines of communication open with him.

Our beloved son, the child that was praised by teachers as somebody who would be the next Prime Minister, became ill at 13. He is now 31. His health status is very poor, as is typical of people who have been chronically ill and who have been living on the streets for a long time. He suffers, like many other people do on our streets, from mental illness as well as addiction.

For all of the years, in our experience, our family has never been able to access the services that Christian needed—from diagnosis early on, when it was important, to medication, to primary care throughout his adolescence and adulthood—as well as the social supports that he would need.

Like many other young people who become ill, his illness and addiction were, at the beginning, seen as a teenager that was acting out or experimenting with drugs. For all those years we as his parents were rarely able to either give or receive information that would have been key for treatment or key for follow-up, due to the silence and confidentiality that usually falls when a young person or an adult becomes ill.

We want you to know that we understand that families, and particularly parents, have to be assessed to see if they might be a part of the problem. We expect that and we respect that. In our case, as his parents, we loved him, we knew him best and we knew that he was ill.

Mr. Germain Dubois: If you know our city, you will know how homeless people gather on Murray Street and around the mission to receive services and beg for money for drugs. You no doubt have the generosity of spirit to acknowledge that homeless persons are sons and daughters, brothers or sisters, mothers or fathers. In our case, our son became one of the homeless community. So many families are unable to maintain a relationship with their loved ones who suffer from concurrent disorders because they have not been able to access education and other supports to learn how to live with such deadly diseases. Over the years, we had to educate ourselves about concurrent disorders. Catherine, for one, was in a group of family members who were trained to give Family to Family, an education program operating out of CMHA delivered by family members here in Ottawa. Family members paid for the training, paid to take courses and maintained the program for going on 10 years. For all these years, we have struggled as a family to help our son receive appropriate treatment while keeping our family together through crisis after crisis, including suicide attempts, broken limbs and broken hearts.

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Ms. Catherine Dubois: This year while accompanying our son through the court process, we met staff at Horizons Renaissance who are supporting Christian through the process. We were invited to take the family education course. We already knew so much of the material because we had to know it. We attended because we thought it would help our son in some way, that it

would allow the facilitators of the course, who were there representing Montfort Hospital, Maison Fraternité and Horizons Renaissance—that somehow they would hear about him and it might shine more light on Christian and know what might be helpful to him. For the first time in our lives, and our son is now nearly 32, we had the opportunity to hear and be heard by expert resource persons. We waited over 15 years. We're extremely appreciative of this opportunity, and that's why I wanted to mention those organizations more than once to you. For us, these workers and any other person that's helped our son along his road are heroes to us.

If Christian was here, I'm not sure that he would be able to express to you hope. He was not treated effectively as a teenager, as a young adult, and because he was not treated effectively, he has now the experience of living with serious and persistent mental illness and addictions to the degree that it's life-threatening. We don't know if he can maintain his apartment because the supports that surround him still after all these years are so tenuous. We know what we do: We have one day a week with him, but we obviously can't do seven days a week.

We want you all to know that from our perspective, parents would remain committed and effective supports to their children if they could be regarded as partners in care. We will continue to be part of our son's care for as long as we can and as long as he lets us. So we want you to see us as two of the many thousands of parents that you might already have been meeting as you do your work. We are pleading for more robust education programs and we are pleading for a process that empowers parents and providers to work together to improve care for people who live with concurrent disorders. We care deeply about the dignity of each and every person that experiences this in our province and in our country.

We hope and we trust, as we look at you, that governments and all your partners have the resources, the knowledge and the abilities that you have to make sure that services are improved and that consumers of services can provide adequate care. We would be happy to have any questions that you would have for us.

The Chair (Mr. Kevin Daniel Flynn): Good. Thank you very much for coming today. That was a great presentation. Let's start from this side. Any questions? Liz.

Mrs. Liz Sandals: Thank you so much for sharing your story. As you've described, you very much wanted to be able to be involved to support your son, to provide the information about what you were observing, but you found an obstacle to that partnership between the parent and the medical systems. Can you identify what the obstacles were? Was it legal obstacles or was it attitudinal or some other factor that was the obstacle?

Ms. Catherine Dubois: I think there are legal aspects in terms of confidentiality, once a person reaches a certain age, and those things are in place for good reasons, but I think that parents and families can quickly be assessed to see that either they're part of the problem or they can be part of the solution.

In our community, and I'm sure you hear this all throughout the province, we did not have a lot of choice in terms of good psychiatric care. In fact, we found that a lot of medical professionals will run away from it because they just feel that it's an area specialty they're not trained for. So it's very difficult to get the support early on.

I think the key to effective treatment is early diagnosis. We're just one family out of thousands who now find ourselves with a son whose future is not what it could have been. It's really not what it could have been. My husband will often make the case, and did so this morning, saying, "We're not really going to have the time to say what we feel," and we know that. But he was saying this morning, "How much money is it costing the system for all of the services that our son needed that didn't even work?" We would just really try and make a case for services at the beginning of the process. Especially for a young person, you don't have a huge window. When that child needs help, the child and the family need it then because there are so many ways that the child, as he grows, can disconnect. And when that person is also ill, my goodness, and would be experiencing all sorts of psychotic episodes, for example, and is self-medicating because in that young person's view nothing else works, it's a long journey down.

Mrs. Liz Sandals: Thank you so much.

The Chair (Mr. Kevin Daniel Flynn): Thank you, Catherine. Christine?

Mrs. Christine Elliott: I'd also like to thank very much for being here today. We have heard from a number of parents and families. I just want to assure you, on behalf of the whole committee, that this is something that we're taking very, very seriously. We do want to find a solution so that other families won't have to go through what you've had to go through with your son.

One of the previous presenters mentioned that you can have housing, but without a treatment and care plan it's not going to work. It sounds like you're sort of in that situation right now with your son. What do you think he would most benefit from right now? What supports would you like to see in place to make sure this will be successful for him?

Ms. Catherine Dubois: He needs supports every day. Ideally, there would be a period where it would be easy for hospitalization for those episodes where he needs treatment in a very concentrated way, but at the very minimum he would need people to support him throughout the week. Now it's pretty well an optional thing.

The only thing we're really sure about is our day where we can go and help maintain the apartment and help see that there's food, and also be his parents. We want to be parents. We're not qualified to be mental health care experts. So we're looking for all of the organizations to see who's going to be doing what. It's either all or nothing for families. You're expected to do it all or else it seems, in our experience, you're totally excluded. What would help is if he would have someone to check in on him to make sure that things weren't

sliding and to see if his meds were happening. Now our son walks in the morning over—I don't know—

Interjection.

Ms. Catherine Dubois: —a distance from his apartment to the Salvation Army to pick up his medication in the morning and to pick up his medication at night. On one hand, that's helpful because he has routine. On the other hand, there are lots of ways that that can go off the track. It's not easy. Why does it have to be so hard for somebody who's so ill?

The Chair (Mr. Kevin Daniel Flynn): Thank you, Catherine. France?

M^{me} France Gélinas: Nous avons beaucoup entendu parler, madame, monsieur, des parents qui se sentent exclus, puis ils sont exclus à cause de lois de confidentialité. Pouvez-vous me donner un exemple précis, au début avec votre enfant; si vous aviez eu la chance de vous expliquer mais on ne vous l'a pas donnée?

M^{me} Catherine Dubois: La première fois que cela nous est arrivé, on est allé ensemble à notre médecin de famille qui était avec nous depuis sa naissance. On a demandé à Christian d'entrer dans la salle d'examen. Moi, j'étais exclue, puis je n'avais aucun moyen de partager. Notre médecin de famille n'était pas vraiment à l'aise avec ça. Être à l'aise avec ça, je le comprends, mais il n'a pas fait un aiguillage à quelqu'un dans le réseau de santé mentale.

Christian était suivi par un psychiatre pour une période assez courte. Puis ce qui a été partagé avec le psychiatre, nous autres n'en étions pas au courant, même si c'était nous qui amenions Christian pour les rendez-vous. C'en est un exemple.

Ça fait deux fois que Christian a été hospitalisé quand il était jeune. La première fois était à 16 ans pour un essai de suicide. Après, il a été mis dans la rue sans même un appel à sa famille, en plein milieu de l'hiver. Je ne comprends pas comment des choses comme ça peuvent arriver.

M^{me} France Gélinas: Il faut une balance entre le droit à la vie privée et le droit au traitement. Je pense qu'on n'a pas trouvé la bonne balance en ce moment parce qu'on a attendu parler de beaucoup de cas comme la vôtre, madame.

1620

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for coming today. Thank you for telling your story. I think you got your point across very well.

MARIE-JOSÉ DEALBERTO

The Chair (Mr. Kevin Daniel Flynn): Our next speaker today is the 4:15, Marie-José Dealberto.

Dr. Marie-José Dealberto: Thanks for inviting me to give this talk on the increased risk for autism, schizophrenia and psychosis in immigrants. I am a psychiatrist and epidemiologist, and also I am an immigrant. Today I will speak as an immigrant and as a scientist. I come from France so I have a very strong French accent.

The increased risk for autism, schizophrenia and psychosis is a very sensitive issue in our multi-ethnic society. Canada is a country of immigration and there are six million foreign-born, according to the 2006 census, representing 20% of the population. The figure is more striking when you consider together the first and second generation of immigrants: 40% in Canada, 54% in Ontario and 76% in Toronto. I am considering both generations because we see the risk affecting both generations.

Autism is a neurodevelopmental disorder characterized by a deficit in social interaction and communication, and repetitive behaviour. Psychosis is a disorder of thought and sense of self, and schizophrenia is the most devastating and incapacitating type of psychosis, characterized by hallucinations, delusions, and emotional and social withdrawal, with cognitive symptoms. Schizophrenia is also considered as a neurodevelopmental disorder. There are other types of psychosis and I would like to insist on late-onset psychosis or very-late-onset schizophrenia-like psychosis, which affect elderly and very elderly subjects.

The human costs of autism and psychosis are enormous, but the financial costs are very important too. A US study estimated the cost of autism at \$3.5 million per case, lifetime. A UK study estimated the cost at C\$1.4 million to C\$2.2 million, lifetime per case. For schizophrenia, the total cost was estimated at \$6.85 billion in Canada for the year 2004.

The risk for schizophrenia associated with immigrant status is well known in Europe, and a recent meta-analysis calculated that overall the risk was 2.9. It means that immigrants are 2.9 times more at risk for schizophrenia than native-born subjects. What is important is that the risk differs according to generation because the second generation is more at risk than the first one. The risk for the second generation is 4.5 and for the first one is 2.7.

What is also important is that the risk differs according to skin colour. Black subjects are at an increased risk than other subjects. The risk associated with black immigrants is 4.8; it is 2.3 for white and 2.2 for other immigrants.

As this meta-analysis is concerned mostly with northern Europe, I reviewed studies in traditional countries of immigration and I found, similarly, an increased risk of schizophrenia in immigrants to traditional countries of immigration, such as Australia, Canada, Israel and the United States. The increased risk for schizophrenia differs also according to skin colour. We have seen that the risk is increased in black immigrants to northern Europe, but there is also an increased risk of schizophrenia in black subjects living in the United States, and most of them have been living in the States for a generation.

What is important to notice is that there are no increased rates in Africa and the Caribbean. This means that black immigrants to northern Europe and black subjects living in the United States are exposed to risk

factors for schizophrenia, and these risk factors do not exist in Africa or in the Caribbean.

There are Canadian data which show similarly an increased risk for immigrant status, an increased risk in immigrants to British Columbia between 1902 and 1913, an increased risk for foreign-born subjects compared to Canadian-born, data for all Canada by Malzberg and De Hesse. And I recently found an increased risk in foreign-born compared to Canadian-born in a sample of homeless persons in Ottawa. There is also an increased risk according to skin colour, and I found, with Sarah McDermott, an increased risk in black immigrants to Canada in a large cohort of immigrants arriving between 1985 and 2000. Also, the first-episode psychosis programs in Ontario found an over-representation of black subjects.

The situation is exactly the same for autism. There is an increased risk of autism in children of immigrants to northern Europe and an increased risk for autism in black children in North America. This increased risk is observed in immigrants for autism, schizophrenia and psychosis, but only for these disorders. There is no increased risk for other mental disorders.

The causes are probably neurobiological because there is exactly the same relationship for autism and schizophrenia regarding immigrant status and skin colour. The most probable cause is a vitamin D deficiency because subjects with dark skin need longer sun exposure to synthesize vitamin D, so they are more prone to vitamin D deficiency when they live in high latitudes, as in Canada. Vitamin D deficiency during pregnancy would be responsible for autism and schizophrenia, and vitamin D deficiency through epigenetic mechanisms would be responsible for an increased risk for schizophrenia and psychosis in immigrants.

In conclusion, immigrants to Canada and visible minorities are overburdened by the most severe mental diseases at all stages in their lives. Because of its large population of immigrants and its high northern latitude, Canada has probably one of the highest rates of schizophrenia. There is an urgent need for reliable estimates of rates of autism, schizophrenia and psychosis according to immigrant status and skin colour.

Action: I think it's very important to design mental health programs specifically for psychosis aimed at immigrant communities and visible minorities. There are specific programs for immigrants, but they are not specific for psychosis. These special programs would improve diagnosis, treatment and awareness and decrease stigma. There is a need for funding for epidemiological studies and there is also a need for funding for neurobiological research on both the pre-natal and direct effects of vitamin D deficiency.

Of course, the best action is prevention, and if there is enough evidence, prevention of autism and schizophrenia by monitoring vitamin D levels and treating vitamin D deficiency in pregnant women, especially those who are dark-skinned, immigrants and veiled; prevention of schizophrenia and psychosis by monitoring vitamin D levels and treating vitamin D deficiency in immigrants

and visible minorities. The cost is minimal because the cost of two vitamin D serum levels and treatment per year is inferior to \$150 per person.

Thank you.

1630

The Chair (Mr. Kevin Daniel Flynn): Thank you. That was very interesting. You left a lot of time.

Dr. Marie-José Dealberto: I welcome your questions but English is not my first language, so please speak slowly and articulate so I will be able to understand you.

The Chair (Mr. Kevin Daniel Flynn): No problem.

M^{me} France Gélinas: On a l'interprétation simultanée, si vous—

D^{re} Marie-José Dealberto: Ça va. Si je ne comprends pas, je vous le dirai.

M^{me} France Gélinas: Parce qu'ils sont là.

The Chair (Mr. Kevin Daniel Flynn): Okay. First questions are from this side. Anybody? Helena?

Ms. Helena Jaczek: Yes, thank you. This was very interesting. I note that you've looked at this meta-analysis by Cantor-Graae and Selten, 2005. My understanding of meta-analysis is that this is where you take many smaller studies and, to increase the power and the number of subjects, you combine them, ensuring the methodology is appropriate, that they can be combined, and then you reach a conclusion.

What has been done to date in terms of longitudinal studies in terms of rates—let's use schizophrenia—in Canada over time? I'm a physician and I have a master's in epidemiology. Meta-analysis is useful to point people in the right direction, but I'm just wondering what do we have subsequent to that in terms of following rates of admission etc.? Does CIHI have any data related to immigration, ethnicity and schizophrenia?

Dr. Marie-José Dealberto: I'm sorry but I'm not sure I have understood your question.

M^{me} France Gélinas: Helena est médecin et elle a un degré en épidémiologie également. La méthodologie que tu as utilisée avec les meta—elle décrivait comment c'est fait, mais elle aimerait savoir s'il y a des études longitudinales également qui démontrent et appuient ce que tu nous présentes aujourd'hui. Elle faisait référence à différentes banques de données qui existent au Canada qui permettraient de faire ce type d'analyse longitudinale.

Dr. Marie-José Dealberto: The best studies for schizophrenia are incidence studies. It means that we study new cases of schizophrenia. To my knowledge there have been no recent studies. The only two studies on new cases of schizophrenia in Canada were performed by Malzberg in 1964 and De Hesse in 1967. There have been no recent studies since that time.

Ms. Helena Jaczek: That's very interesting. It seems a glaring omission.

The Chair (Mr. Kevin Daniel Flynn): That's right.

Dr. Marie-José Dealberto: Yes.

The Chair (Mr. Kevin Daniel Flynn): Thank you. Any questions? Sylvia?

Ms. Sylvia Jones: Just one, thank you. Under "Prevention," you mention that vitamin D levels should be monitored for women who are pregnant. It's been a

while since I was pregnant. Is that something that is a standard physician test at this point for pregnant women?

Dr. Marie-José Dealberto: Your question is, is there enough evidence to test all—

Ms. Sylvia Jones: No, my question is, do doctors test vitamin D levels in pregnancy right now?

M^{me} France Gélinas: Elle veut savoir si en ce moment, lorsqu'une femme est enceinte, on regarde son niveau de vitamine D.

Dr. Marie-José Dealberto: I am not an obstetrician or a gynecologist so I am not aware of that; I don't think so. Some GPs systematically request vitamin D for their patients. But right now, for obstetricians, I am not aware of that. I will inquire. Thank you for your question.

The Chair (Mr. Kevin Daniel Flynn): Thank you. France, do you have a question?

M^{me} France Gélinas: C'est quand même très révélateur ce que vous nous avez dit, avec une solution qui est tellement simple : de la vitamine D. Ça s'achète à l'épicerie pour à peu près quatre sous pour mille unités internationales, une masse pour ta journée. Puis, si cela a des conséquences comme vous dites—4,8 fois plus de cas de schizophrénie, puis que ça pourrait être diminué de plusieurs pourcentages avec quelque chose d'aussi simple. J'appuie ce que ma collègue a dit, qu'on a besoin d'une étude longitudinale et de regarder ce que vous nous avez présenté plus en détail—pas qu'on doute de ce que vous avez fait mais vraiment, de notre côté également, voir ce qui existe. Si vous avez des pistes pour nous pour poursuivre ce que vous nous avez dit aujourd'hui, des pistes qui existent déjà—on a des gens qui font de la recherche pour nous et c'est certainement quelque chose qu'on va regarder.

Dr. Marie-José Dealberto: I think it's very important to continue research on this topic, but this increased risk of psychosis and schizophrenia is a taboo topic in Canada. So I am very, very thankful for the committee giving me this opportunity to speak about that and to speak for immigrants too. While I was working as a psychiatrist in Ottawa, I saw too many immigrants alone in Canada, without family, without support. There are more tragic stories than you can imagine. So I really want to continue working on that. I really understand that the committee needs more evidence, and I am working to continue collecting more evidence.

The Chair (Mr. Kevin Daniel Flynn): Thank you very much for your presentation. That was very interesting, very intriguing.

PROVINCIAL CENTRE
OF EXCELLENCE FOR CHILD AND YOUTH
MENTAL HEALTH AT CHILDREN'S
HOSPITAL OF EASTERN ONTARIO
CENTRE D'EXCELLENCE PROVINCIAL
AU CHEO EN SANTÉ MENTALE
DES ENFANTS ET DES ADOS

The Chair (Mr. Kevin Daniel Flynn): Our final speakers of the day are Dr. Ian Manion and Dr. Simon

Davidson of the Provincial Centre of Excellence for Child and Youth Mental Health at Children's Hospital of Eastern Ontario. Thank you very much for coming today. I understand there was a little confusion as to your time today. Did you prepare for a 15-minute or a 30-minute presentation?

Dr. Ian Manion: We're very flexible. You guys look tired.

The Chair (Mr. Kevin Daniel Flynn): Okay, let's make it 22½.

Dr. Ian Manion: Perfect.

The Chair (Mr. Kevin Daniel Flynn): We're all yours.

Dr. Simon Davidson: Thank you for allowing us to present. We do realize that you are toward the end of a really long day.

That said, we would contest that whether we're talking about mental health or whether we're talking about mental illness, it all begins with children and youth. Romanow talked about mental health services as the orphan of health care services. Kirby took that a step further and said, that being true, child and youth mental health services are the orphan of the orphan.

The Chair (Mr. Kevin Daniel Flynn): I'm sorry, before you go on, you're going to need to identify yourselves as you're speaking; otherwise, the guys from Hansard won't know who's who.

Dr. Simon Davidson: Sorry about that. I'm Davidson.

Dr. Ian Manion: I'd be Manion, then, by exclusion.

The Chair (Mr. Kevin Daniel Flynn): You're the other guy.

Dr. Simon Davidson: We wanted to congratulate the committee on putting together a really fine document. At the end of the day, the devil is going to be in the implementation of this document.

As I've already said, children and youth are where it all begins. Children and youth are not just little adults, and the approaches to intervening with them have to be different. The other caution is that in health care—and I was the chief of staff at the Children's Hospital in a prior life for about 10 years—there's considerable evidence that in across-the-lifespan initiatives—and I actually support this being across the lifespan—the ends of the age span get forgotten. So children and youth and seniors are often falling off in across-the-age-span initiatives.

The other thing that's really important—and again, kudos to this committee. In my 30 years in the field, I have never seen cross-ministry communication as good as it is today. It isn't that great today, but it's there and it's better than ever. For this initiative to succeed, cross-ministry integration is going to be fundamental. So for children and youth, that at least includes the Ministry of Children and Youth Services—MCSS—the Ministry of Health and Long-Term Care, the Ministry of Education, and probably others.

Finally, on the point of children and youth, for those of you who don't know, we have very good evidence at this point from multiple sources that more than 70% of adults living with mental illness had their onset at an age

less than 18. So it's not rocket science to say if you make a fairly modest investment early on, you may have a better chance later on.

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The second and last point I'm going to make before passing it on to my colleague has to do with the whole issue of a different kind of balance. The first balance was across the age span; the second balance is across the continuum, because when you have an underresourced system, you tend to invest all your money in the deep-end, more expensive, more intensive services. Two presenters ago, the point was made about early identification and early intervention and how important that is. It has truly been a privilege for me to have worked with that subcommittee of your committee. In fact, we have our first meeting post-report tomorrow morning of the early identification and early intervention committee.

So we have to make sure that health promotion and illness prevention is really a solid component of the full continuum if we're going to make sure that every door is the right door. Thank you.

The Chair (Mr. Kevin Daniel Flynn): Just to correct something, we're getting some credit for something that we probably shouldn't get credit for. As much as we like credit, we probably shouldn't take it.

There are two streams that are going on at the same time. The minister has an advisory group, of which you're probably serving on a subcommittee.

Dr. Simon Davidson: Yes.

The Chair (Mr. Kevin Daniel Flynn): They prepared the report Every Door is the Right Door, and that's out for comment right now. At the same time, our committee is meeting as a committee of the Legislature, which involves all three parties.

Dr. Simon Davidson: I'm aware of that.

The Chair (Mr. Kevin Daniel Flynn): It's a private initiative, and we're going down the same road. I shouldn't say it's a private initiative, but it's not a ministry initiative; it's a Legislative Assembly initiative. It's a select committee, which is quite rare. So as much as I'd like to take credit for the report, and I share your opinion that it's a pretty good one, we didn't write it. But I think we're all trying to end up in the same place. Our task is to report to the Legislature next spring on a comprehensive strategy. The minister is working on a much longer-term view, on a 10-year comprehensive strategy. So I just wanted to be clear, but we'll take any more compliments you have as well.

Dr. Simon Davidson: Well, I'm done.

Dr. Ian Manion: That's a particularly nice tie you're wearing today.

We've actually circulated some information about our centre. We think that some of the work that we're doing is quite important to the conversations you're having presently.

I'm not sure how familiar you are with the Provincial Centre of Excellence for Child and Youth Mental Health. We've been around for about four years, and we are a provincial resource funded by the Ministry of Children

and Youth Services. Our vision is for the best mental health and well-being possible for every child and youth.

Nous sommes une ressource bilingue. On a des services en français et en anglais, et on travaille très fort pour que tout qu'on puisse offrir est disponible dans les deux langues. If you have any questions in French along the way, please don't hesitate to ask them.

The way that we do our work is by really building on three different pillars: knowledge, capacity and partnerships. In terms of knowledge, there is so much information out there on child and youth mental health that never gets into the right hands for it to be useful, whether that's in the hands of a parent who's looking for assistance, a young person who is trying to find their way in understanding what they might be experiencing, a service provider who knows that they have needs in the community while not necessarily being aware of the best way to meet those needs, a researcher who's trying to fill some information gaps, or even a policy-maker who is trying to make policy that can influence in a very positive way the lives of children and youth and their families.

What we try to do in terms of knowledge is bring all the knowledge together in one spot. We collate existing knowledge: What do we already know, and are we using it? Unfortunately, too often we re-research to death the same topics over and over again, and we're very good at keeping that information in very isolated places. So how do we make the information alive? How do we mobilize it? How do we make it move to people who can actually use it? Sometimes by doing that, we identify knowledge gaps, so how do you create new knowledge to be able to inform the activities that we do to improve the lives of children and youth?

In terms of capacity, we work a lot with the front-line service providers. How do we equip them to better use information to be able to plan their services, implement their services, but also evaluate their services so they know they are doing a good job not just in their hearts, but in what they can also measure and build upon on a day-to-day basis?

From a partnership perspective, we partner with everyone, and I really applaud the non-partisan approach that you have taken to having these conversations. Unless it becomes an issue that relates to everyone, where it's everyone's business, we're not going to get anywhere. There's been too much fragmentation, particularly in child and youth mental health, but you could argue right across the age span. Only efforts like this can start bringing those things together.

That's why we consistently partner with all those who are doing significant work in child and youth mental health, whether it's direct or indirect. Of course, we partner with policy-makers and researchers and front-line service providers, but we also partner with people in other sectors, whether it's education or youth justice or child welfare, developmental services or recreation. All these have roles in terms of outcomes for children and youth.

We also work directly with parents and with young people themselves. I believe you heard from an amazing

young person this morning, Anie Belanger, who has been associated with our centre from its inception, and actually before then, in some work that Simon and I have been doing in youth programs in this community and across Canada. How can you not want to listen to that energy, that creativity and that commitment? We might be able to develop a system that we think works for others. The reality is, they have to help us build the system for them; it's a partnership. It's not a "to them"; it's a "with them." The same thing goes for parents. You heard passionately from parents already. I was sitting and listening to the Dubois story. You can't help but be moved and wonder whether, if they had been partnered with more effectively along the way, their experience would have been a more positive one.

We wonder about how we can help you in your process. Obviously we have some expertise that we think might be valuable to you, whether that's in research and evaluation or even the development of indicators. We've worked with some of the different ministries in terms of indicator development for their agendas, whether it's in mental health as it relates to child health or in the Ministry of Children and Youth Services.

We have access to knowledge. We're constantly sifting through the knowledge base. Right now, an area of particular interest for us is school-based mental health and addictions. Again, there is a massive data set that is virtually untapped in terms of how we're using information effectively in our schools. There are wonderful programs all across the province and actually across the country, and yet we keep those pieces of excellence, pockets of excellence, some of the best-kept secrets around.

So how can we benefit more from each other's experiences and link people together so they can share their stories?

Training: We are developing tool kits and webinars and using technology, but also we see the importance of bringing people together to form networks and partnerships where they can have these conversations. Again interestingly enough, one of your speakers was talking about FASD. We've been approached by networks—we have been the glue that has allowed these people to come together and to further their communication so they can get their word out.

You've heard of some of the work that's been done in terms of youth engagement. I won't go through that in detail. We are also involved in the Ministry of Health and Long-Term Care's consultation process for their document. They've asked us to facilitate some of their consultation with young people. We are not going to have them speak to a group of one or two young people; we're going to have them speak with several groups of young people from across the province. Not all young people are the same, so the solutions can't all be the same.

We work hard on innovations. We have grants and awards programs at our centre, but they are all a little bit different based on the realities of what we have seen in

in touch with you with further questions and further issues.

I'm really interested because one of the things that we've heard from family members is that they've taken their children to family physicians, and they haven't really known what to do because they don't receive that kind of training, maybe, or they just don't feel equipped enough to handle it. So the HealthCheckPlus program is really interesting. It could fill a really important gap.

Could you just explain a little bit more about the kinds of things that it does? Does it assess whether the child needs to be referred on to a psychiatrist or psychologist? Does it give them some kind of an indication of whether there's a serious problem here or whether it's just, "You're a teenager; you're growing up" or whatever?

Dr. Ian Manion: That's an excellent question. It's based on a number of evidence-based screening questions. They start with very broad questions, depending on what the needs are from that physician and what they think they want to screen for. If you get enough hits, it gets more and more specific. So if it's just a general kind of angst and normal things, the questions are very superficial. No questions will end the interview. The more severe the problem, the more in-depth the questions become. It flags things for the physician, who then may request a more specialized assessment.

Right now, because the physicians are not trained on that, they may be asking questions about headaches and stomach aches and all kinds of things, looking for physical health concerns. We also know that those symptoms are often indicators of mental health concerns. So it assists a more comprehensive view of the physical and mental wellness of that patient presenting to that office.

The Chair (Mr. Kevin Daniel Flynn): Thank you. France?

M^{me} France Gélinas: Does the Provincial Centre of Excellence for Child and Youth Mental Health—

Dr. Ian Manion: It's a mouthful.

M^{me} France Gélinas: Yes. Does it have a position toward peer support?

Dr. Ian Manion: We have many positions on peer support. A lot of the youth engagement work that we do looks at youth-to-youth in terms of support. Our roots are in a program called Youth Net, which is a for-youth, by-youth program which started in Ottawa but now is across the country, and very much, how do you facilitate those conversations but with the safety net there? In other words, don't just leave people to their own devices. Make sure they are also linked up to the system that can support them when those situations become more challenging.

What we have done, as we have developed directories identifying researchers and programs in the province, is we have, on our website, put up a peer-to-peer support so that you can identify those programs in your community that offer peer-to-peer support. There's some research that needs to be done in peer support. There's an existing literature. It's not as clean as it could be. So that's one of our gap areas in terms of information.

We can see ourselves funding further research in specific areas around that. I think we've received a request looking at parent-to-parent support in Asperger's and autism, for example, and the effectiveness of that, based on more sound methodology.

I don't know if that answers your question or not.

M^{me} France Gélinas: Yes, it does.

My other one is, do you have a position on the law that prevents sharing of information with the parents once the child reaches a certain age? We've had a number of parents truly unhappy with where the balance lays, with catastrophic consequences on their child. Do you have a position on that?

Dr. Ian Manion: I won't speak for my colleague, but as I think you mentioned previously, it very much is a balancing point. We do a lot of work with young people. In certain circumstances, parents are their greatest ally, and not only do they want parents to have the information, but they encourage parents to be present. In other situations, parents may be contributing to some of the difficulties, in which case it might be counterproductive. We've had some situations, not in this program but in previous programs, where young people suffering from their first psychotic break or who are suicidal have had their parents refuse to allow them to get treatment, for the stigma that would cause them, the fact that it would ruin their career, even if this person was suffering quite significantly. So we're aware of the need to have balance.

We have conversations with parents and we have conversations with young people. That issue of where the consent lies actually has been an issue raised in our joint group, what's called our consumer and advocates network for the centre. We have parents and young people on the same committee, co-chaired by a young person and a parent, and they hash out these kinds of issues and make recommendations to us that we can then use to inform policy-makers.

Dr. Simon Davidson: What I would add to that, and I would strongly agree with what Ian has been saying, is that I chair the child and youth advisory committee for the Mental Health Commission of Canada, and we have parents and we have youth on that committee. In the very first meeting, this was exactly where the tension was, and when you put the parents and the youth together and they talk it out, they are much better able to find where the balance is. I think when we try to do this, we must include the people with lived experience and their parents. We shouldn't, as professionals, try to determine it on our own.

The Chair (Mr. Kevin Daniel Flynn): Thank you. Any questions?

Mrs. Maria Van Bommel: I was looking through your presentation paper here, and there are a number of things that we've already encountered today—the Dare to Dream, when you said engage—that are being mentioned in here as well. But I also noted that it says here approximately 50% of all psychological disorders emerge before the age of 14. What is the youngest age at which you can diagnose a psychological disorder?

Dr. Simon Davidson: Well, there's a whole area of infant mental health. In my own experience, I was doing an assessment of a family where there was a 14-year-old who had pretty profound depression, and his parents were there. This was a program for school refusal, and this young man hadn't been to school for more than two years; he couldn't get there. I asked the mom, "How long do you think your son has been depressed?" She said, "Since before he was two." I said, "How did you know that?" And she said, "Tell me that it's not depression when on Christmas Day your son prefers to stay in bed rather than get up and open his Christmas gifts."

Mrs. Maria Van Bommel: Certainly, a child not getting up on Christmas Day is an indicator of something very serious, so what would a parent do at that stage?

Dr. Simon Davidson: Well, parents are in a real bind, and you're touching on a really passionate area of mine. Parents often are worried that they've caused it because their parenting wasn't good enough. Inevitably, that's not true; they've done the very best they could. But the stigma of worrying about that often precludes them from getting attention as early as possible.

The other point is that if we're looking at prevention, there is all kinds of international evidence about parenting that works well. Why do we not put together universal parenting programs for different aged kids, available in different modules, whatever the preferred learning style of the parent is, so that they could take these courses? I would suggest that they take a little test at the end of the course and get some kind of benefit, a tax benefit or something back from government, for taking it. That would allow them to know what normal development should look like and how best to parent their kids, and I think that would go a long way, from a prevention standpoint, to reducing the prevalence of mental health problems in our children and youth.

Mrs. Maria Van Bommel: Is there a parenting program anywhere right now that would—

Dr. Ian Manion: There are many.

Dr. Simon Davidson: Yes, there are parenting programs available all over the place, but I would suggest that for the most part, the people who need them the least get them the most. That's why you need to have some kind of carrot at the end of it to encourage people to take it.

The Chair (Mr. Kevin Daniel Flynn): Thank you for coming today. Your input certainly was appreciated. Thanks for taking the time.

Dr. Ian Manion: Safe travels.

The Chair (Mr. Kevin Daniel Flynn): Thank you.

Dr. Ian Manion: You're off to Thunder Bay?

The Chair (Mr. Kevin Daniel Flynn): We're off to Sudbury next, then eventually Thunder Bay.

Okay, that's our business for today. We're adjourned to Sudbury, and our bus leaves the hotel at 5:45 from the same place it dropped us off yesterday.

The committee adjourned at 1659.

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